Health Management™ Associates

December 19, 2012

Bert Fish Medical Center

401 Palmetto St.

New Smyrna Beach, FL 32168

Attn: Steve Harrell

Re: Response to RFP of Southeast Volusia Hospital District

Dear Steve:

Health Management is pleased to submit our partnership proposal with Bert Fish Medical Center, so enclosed please find seven (7) hardcopies with an electronic version to be sent via e-mail. Thank you for considering us again for this important community asset. As indicated in the RFP we have offered both a straight lease as well as a joint venture agreement similar to our arrangements with both Orlando Health and the University of Florida / Shands Healthcare. This approach is similar to our proposal from two years ago, except with this proposal Orlando Health has agreed to act as our Clinical Partner and we would also work closely with Shands Healthcare to improve additional clinical expertise from our existing relationship with them as well as their relationship with Orlando Health.

Altogether the proposed partnership between the Southeast Volusia Hospital District, Bert Fish Medical Center, Orlando Health, and Health Management will provide the very best opportunity for advanced clinical care, new service capacity, and a clear future for patients, physicians, and employees in South Volusia County and the surrounding region.

Please let me know if you have any questions or feedback.

Sincerely,

Pete Lawson

Executive Vice President – Development

CC: David Butler

December 19, 2012

Southeast Volusia Hospital District

c/o Community Hospital Consulting, Inc.

5801 Tennyson Parkway, STE 550

Plano, TX 75024

Attn: David Butler

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1. **<u>The identity of the Respondent</u>** - Health Management own and operates 70 general acute care hospitals, as well a variety of ancillary businesses (ranging from multispecialty physician practices, surgery centers, outpatient diagnostics, home health, hospice, assisted living, skilled nursing etc.) in a variety of communities in 15 states. We currently operate in Alabama, Arkansas, Florida, Georgia, Kentucky, Mississippi, Missouri, North Carolina, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Washington, and West Virginia.

   Health Management's history and future is tied to basic Guiding Principles which ensure that we are the hospital of choice for the patient community, we are the organization where physicians want to practice, and we are the employer where associates want to work. To accomplish our Mission, we practice the following leadership principles throughout the Company:

Guiding Principles:

Health Management (NYSE: HMA) is pleased to inform BFMC that it was recently recognized by Fortune Magazine as one of the **World's Most Admired Companies in Health Care for 2012**. Within that category, Health Management was named the **No. 1 company in Quality of Products/Services and in Social Responsibility**.

FORTUNE WORLD'S MOST ADMIRED COMPANIES 2012

Also, recently, while The Joint Commission named 18 percent of America's hospitals as ***"Top Performers"*** in process of care measures, 64 percent of Health Management's hospitals were recognized with this distinction.

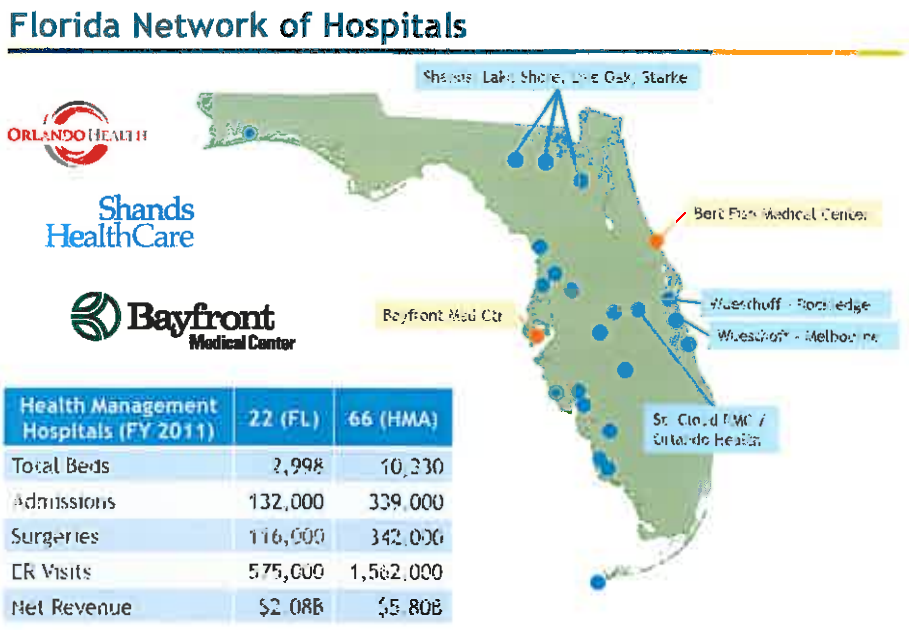
And several of our hospitals have been named by US News as among the best regional hospitals in the nation. Among these are Heart of Florida Regional Medical Center in Polk County, Florida and Sparks Regional Medical Center in Fort Smith, Arkansas. Sparks received this recognition after we acquired the hospital and invested tens of millions of dollars in capital and infrastructure, and Sparks remains one of Arkansas' most important tertiary hospitals.

We are proud that in terms of performance and industry recognition, Health Management has earned a reputation as a quality organization.

Our company is headquartered in Naples, Florida, and started in 1977 with the unique business model of owning and operating non-urban hospitals. Over the last 35 years, the company has grown methodically and serves communities with populations of 50,000 to 500,000 residents. BFMC fits well within our strategy and area of expertise. Our hospitals provide a full range of services, from trauma and advanced neurosciences to virtually all specialties. We have academic clinical affiliations and jointly operate hospitals with our academic partners, including the **University of Florida / Shands Healthcare and Orlando Health**, and we have announced a statewide affiliation between our 11 hospitals in Mississippi and the University of Mississippi Medical Center. We have established a Cancer partnership with Penn State Hershey Medical Center, and our pipeline for these types of partnerships continues to expand.

2. **A description of the Respondent's existing healthcare operations and facilities, including in particular those in Florida** - Health Management is the largest hospital system headquartered in Florida with 22 acute care hospitals plus the recently announced partnership in process at Bayfront Medical Center in St. Petersburg. Bayfront will be a jointly owned and equally governed partnership between Health Management and Bayfront in conjunction with a clinical affiliation agreement with the University of Florida / Shands Healthcare. In addition to Bayfront, Health Management has four (4) hospital partnerships in Florida with not-for-profit health systems including ***St. Cloud Medical Center with Orlando Health and Shands-Starke, Shands-Live Oak, and Shands-Lake Shore.*** Our compliment of hospitals in Florida range from rural north Florida communities to major tertiary hospitals in highly complex and competitive environments.

    a. **What experience does your organization have in operating in Florida and the Southeastern United States** - Health Management has 22 hospitals in Florida treating over 575,000 ER visits, 132,000 admissions, and 116,000 surgical cases annually. In addition to Florida, Health Management operates 32 hospitals in the surrounding Southeastern States of Georgia (3), Alabama (2), Mississippi (11), Tennessee (9), Arkansas (2), South Carolina (2), and North Carolina (3).



b. **How will the Hospital benefit from your existing operations in Florida** - First, by becoming part of a larger system with clinical and financial resources, Bert Fish will benefit from Health Management's purchasing power and negotiating strength – both in terms of supply purchase as well as positioning the hospital for the new payor environment. With nearby hospitals in Brevard County, and a significant footprint of hospitals in Florida, combined with our clinical affiliation with the University of Florida / Shands and Orlando Health, Bert Fish will be a necessary part of any network developed for contracting. Second, because of our clinical affiliations, we are able to extend to our community hospitals and their medical staffs the ability to develop more advanced programs than we could without the connectivity to the academic institutions. For instance, immediate consultation, the development of evidence based protocols, connectivity for trauma and, when necessary, immediate transfer without delay are some of the benefits provided to our affiliated hospitals and medical staffs. **We are approaching Bert Fish with Orlando Health as a Clinical Affiliated Partner, and plan to take advantage of all opportunities to link with Orlando Health to ensure optimum service expansion at Bert Fish.**

c. **If Respondent has no experience in Florida, how will Respondent maintain compliance with Florida laws and regulations** – Health Management is a Florida corporation with headquarters in Naples. As a result we are experienced in all Florida laws and regulations.

3. **Maintain and expand access to healthcare services in the District, including the provision of indigent care** - Health Management will adopt BFMC's existing indigent care policy and also apply Health Management's internal policy of discounting private uninsured patient bills by at least 60% upon discharge. Health Management's hospitals in Florida

provide a significant amount of care for the poor, and in fact, our hospitals rank 3rd in the state in the provision of Medicaid and Charity Care in our Emergency Departments. Many of our hospitals provide in excess of 15 percent Medicaid and Charity days, with some as high as 30 percent. Our track record is reflective of a company that places a high priority on our social responsibility of providing care to those who are in need irrespective of their ability to pay.

Our philosophy is that the more financially secure a hospital is, the better it is able to invest in services that help the poor. When a hospital has a small or negative margin, it cannot make the capital investment to update services and technology, which ultimately deprives the poor of access to these services. On the other hand, when a hospital is secure, it can make appropriate investment, provide services to the poor, and not place itself in financial jeopardy due to the disproportionate impact the cost of caring for the poor can place on a hospital. Therefore, as we have worked with Public hospital authorities in Florida, which we have great experience doing, virtually all of them have provided letters of support to us documenting how we have cared for the poor, made investments, improved quality and improved the financial health of the hospitals – without imposing taxes.

a. **How would the Resulting Organization enhance the Hospital's position as a full-service acute care hospital with at least the same mix and level of services currently offered** - Health Management will retain all existing clinical services for the duration of the lease as required to be licensed as an acute care hospital in Florida and certified as a hospital provider by Health and Human Services (HHS). Health Management has an extensive track record of not only maintaining services, but expanding them. In Hernando County when our competitor hospital in Hernando closed their OB program, not only did we not close ours, we enhanced our partnership with All Children's/Johns Hopkins University to ensure coverage by highly skilled neonatologists for our NICU. We maintain the only NICU in Hernando County, and consistently maintain Medicaid and Charity in excess of 25 percent – one of the highest levels in the state. The same commitment has held true for Santa Rosa Medical Center, Shands-Lakeshore, and Lower Keys Medical Center – all of which maintain among the highest Medicaid and Charity percentages in Florida – and yet we have not reduced services. In fact, we have invested millions of dollars into enhancing and improving them through physician recruitment, capital investment and service line development. By investing human and financial capital into service development locally, a hospital's case mix index generally increases. This has the added effect of increasing the hospital's revenue stream while at the same time, our cost structure is lower due to the economies of scale Health Management brings to the transaction.

    i. **What type and level of services do you believe are essential to this community** - Essential inpatient services for the South Volusia area include Primary Care, General Surgical, Emergency Services, CardioVascular, Women's and Children's Service, Orthopedics, Geriatrics, and Neurosciences. In each of these service lines, we would expect to do a baseline assessment of

the service capabilities, and would develop and execute a plan for achieving the optimum service capability for that service line.

ii. **What would your commitment be to developing new and needed services**- Although all healthcare organizations need to maintain and improve efficiencies; thriving business need to grow volume, market share, and revenue in the short and long term. Consequently, Health Management's success at Bert Fish and elsewhere is intimately tied to creating high quality new services that will give patient's solid reasons to be treated at Bert Fish and not in Daytona or Orlando. We would look closely at out-migration to determine where there is opportunity to expand services that are needed.

b. **Specifically, describe how you would expect the Resulting Organization to reduce outmigration of patients from the Hospital's service area** - Nearly 70% of patients living in the New Smyrna area leave the community for inpatient care in either Daytona or Orlando. This includes basic primary and secondary services that BFMC currently offers and provides on a high quality basis. One of the distinctive qualities of Health Management is that we do not accept the notion of "feeder hospitals", which some communities have convinced themselves their hospitals are. We believe each hospital should live up to its optimum potential, and we invest that way. Each service line is constantly reviewed to determine what the capabilities and service gaps are locally, and we invest in making sure we have the technology capability locally, physician capacity and clinical linkages with tertiary partners to ensure, wherever possible, we provide the service locally. Services beyond our capabilities due to their more tertiary nature are linked to our academic clinical partner – in this case, Orlando Health – not for the purpose of only transferring the patient when necessary, but to ensure there is a continuum of care for the patient in the community when they return.

Patient Egress from New Smyrna Area

Hospital	PSA/SSA
Bert Fish Medical Center	31.7
Halifax Health Med Ctr	34.5
Florida Hospital Memorial	11.9
Halifax Health Port Orange	8.7
All Others	13.2

- PSA & SSA = 90% of patient zip codes for Bert Fish Medical Center
- All Others = hospitals with <2% share

Source: Florida Inpatient data Jan 2011-Dec 2011
The Nielsen Company & Thomson Reuters

Health Management

c. **Please identify, based on your organization's experience, the most critical factors or obstacles in successfully effectuating the transaction and fulfilling the expressed desire of the community and the District** - The most critical factor in successfully completing this and other transactions is to transparently select a potential partner which reflects the community's consensus expectation of BFMC's long standing mission of providing the very best healthcare services and access to local residents. Health Management's Mission of ***Enabling America's Best Local Healthcare*** clearly fits that expectation, especially in conjunction with clinical affiliate support from Orlando Health. We anticipate speedy regulatory approval for this transaction, as there are no anti-trust or other regulatory reasons it would not close timely. Health Management can generally close a transaction within two months of the definitive agreement being signed.

d. **Describe your experience in working with underserved communities** - Health Management has extensive experience serving underserved communities. One example we highlight is in Madison, Mississippi, where a community hospital was going to close. We were asked to manage the hospital after larger catholic and Baptist hospitals in Jackson, Mississippi refused to help. We decided to help, knowing the hospital was in deep financial trouble. Not only did we turn the hospital around, we decided to build a new one. Ironically, the larger Catholic hospital system in Jackson opposed our effort to build a new hospital, and even attempted to obtain the CON themselves. The local community organized their own effort to support our application. We were successful in the CON process and the new hospital is now open. We also point to Hernando County, Florida, where the hospitals were bankrupt. We acquired the hospitals, paid off all the debt to get the hospitals out of bankruptcy ($75 million in debt) and subsequently built a new replacement hospital. The hospital today is one of the highest Medicaid and Charity hospitals in the state, and yet is very profitable. We also point to Lower Keys Medical Center in Key West, Santa Rosa Medical Center in Milton, Shands-Lakeshore in Lake City, and a host of others as examples where we are serving the underserved, expanding our services to earn more compensated patient support, and therefore enhancing our ability to serve the underserved. We believe this formula works, and the results are certainly available to demonstrate it.

e. **What are the priorities of your service area development plan** - Our priorities are developed in collaboration with the Medical Staff and Board leadership, and are data-driven to ensure we properly capture information that will help decrease outmigration and enhance service availability in a high quality manner. The first priority is to conduct a physician and service needs assessment. From this assessment, we determine if we have gaps in programs that can be closed by either recruiting physicians to the community, or investing capital to support the physicians we already have. Our ultimate goal is to keep patients at home locally for their care. We also assess quality by looking at a wide range of quality metrics to determine if there are opportunities to improve. These metrics are evidence based. As demonstrated, we have very high standards for achieving success on objective quality of care measures, and we expect all our hospitals to collaborate with their physicians to seek

a high degree of success on these metrics. We believe it is inappropriate to market services to a community if the quality of care is not superior to that of our competitors. All of these items go hand in hand.

f. **Please describe your organization's current charity care and bad debt policies and programs** - Health Management will adopt BFMC's existing indigent care policy and also apply Health Management's internal policy of discounting uninsured patient bills by at least 60% upon discharge.

4. **Maintain and enhance the long term financial viability of the Hospital (and its physicians)** - In order to maintain the long term financial viability of the Hospital and loyal physician base, BFMC needs to develop an operation plans that allows the hospital to expand and grow without borrowing funds or receiving tax revenue support within 5 years of closing the new transaction. That is Health Management's specific expectation which can only be accomplished by the Medical Staff and Hospital leadership working together to expand services, improve clinical outcomes, add capital, and reverse patient egress.

   a. **Please describe your financial and operational strength, including:**

      i. **Your ability to provide financial resources in the form of cash, notes and/or assumption of liabilities in order to effectuate the transaction. Please provide a description of the expected sources of financing, the anticipated time to obtain such financing and any contingencies thereto** - Health Management is a Fortune 500 company with over $5.8 billion in net revenue for 2011 and cash and credit lines exceeding $700 million. Health Management will lease the Hospital long term with existing cash reserves and/or credit facilities at closing without financing contingencies.

      Annual and quarterly filings can be found on the U.S. Securities and Exchange Commission's website: www.sec.gov

      Additionally, annual reports and financial information related to Health Management can be found on our website: www.hma.com

      ii. **Your ability to fund routine operations (maintenance and upgrades) as well as strategic (major expansions, addition of services, market share expansion) capital expenditure requirements. Please provide evidence of capital expenditures in currently owned facilities** - Health Management spends on average 4%-5% of net revenue company wide annually on capital spending for routine maintenance and strategic expansion. At Bert Fish we are estimating capital spending at a minimum will be $15 million over 5 years. Our experience for new acquisitions is to exceed the estimated amount in the first 2 years with service expansions.

b. **Please describe how the Resulting Organization will reduce or eliminate the tax burden of the tax-payers of the District** - Health Management would seek to eliminate and end the tax contribution from the Southeast Volusia Hospital District as soon as possible after forming the new partnership. Upon due diligence, we will be in a better position to commit to a time frame, but it is our objective for the citizens of the Southeast Volusia Hospital District to pay no taxes toward the support of the hospital. It should not be needed. We have done this with other communities, and are comfortable making this commitment. In addition, as a tax paying organization, the partnership will pay all local, state, and Federal taxes, so the District and the County will receive new tax revenue which will help reduce individual tax payer and businesses tax bill.

c. **Please provide a copy of the following financial statements** - Health Management is a publicly traded company (NYSE: HMA), so its financial records are available on www.hma.com

   i. Audited financial statements for the past three years – www.hma.com

   ii. Interim period (year-to-date) financial statements – www.hma.com

5. **Maintain a local role in governance of the Hospital** - Post closing, the governance role of the hospital will be structured similarly to the existing relation with the mission of providing outstanding care to the New Smyrna community. In the new organization, we will establish a community Board of Trustees which will be structured as follows:

- Comprised of Local Community Leaders, Physician Representatives and Hospital CEO
- Typically comprised of 9-13 members: 60% lay members and 40% physicians
- Establishes strategic direction
- Oversight for regulatory compliance (JCAHO, State, CMS) and patient safety
- Ensures quality of care and Medical Staff credentials
- Collaborates on operational objectives
- Serves as community liaisons and communication champions
- Interaction with & access to Health Management Leadership

a. **Please describe the proposed governance structure (or alternative structures) of the Resulting Organization, and explain how the structure(s) would offer accountability to the communities served by the Hospital** - The Board of Trustees will represent the combined community interests of both local citizens and local physicians who fully support and want BFMC to thrive and grow independent of the two other healthcare districts in Volusia county. As noted above, the Board of Trustees is an advisory Board which will guide Health Management local leadership in developing those path ways without the burden of being fiduciary members. To formalize the representation, Health Management recommends that the Southeast Volusia Hospital District have at least two (2) full time members represented on the new Board of Trustees through the duration of the long term lease.

b. **Please describe how the relationship would work between the Hospital's current governance structure and your organization's board, and the limitations on Hospital's local board authority, including those matters for which approval by your organization's board would be required** - As noted above, the new Board of Trustees will have all of the traditional responsibilities it has now, but not be liable for BFMC's financial performance, namely Quality of Care, Medical Staff Credentialing, Community Relations, Public Affairs, Government Relations, Capital Planning, etc. The Southeast Volusia Hospital District's authority would remain intact from the standpoint that it would be responsible for ensuring Health Management is in compliance with its lease terms. Also, to the extent the hospital district chooses to invest in other health care programs at its discretion, it would have authority over those programs. As it relates to capitalization of the hospital going forward, the hospital district would no longer have that responsibility, and Health Management would have the liability for the investment.

c. **How would the local board have influence on and decision making authority on matters that impact the community? Similarly, on issues that will impact the medical staff?** - The Board of Trustees will play a lead role in Community Relations acting as the hospital's liaison with local businesses, government, and community leaders. Your input and feedback to local Management will help craft business develop, patient access, and job creation. All levels of Management in turn will actively participate in community leadership, volunteer organizations, and civic duties to complement the overall relationships with communities in Volusia County.

   Relative to the Medical Staff, in the organization structure the Medical Staff reports to the Board of Trustees, so the Board will be final authority on Medical Staff credentialing as it is now.

6. **Detailed description of the financial terms of your proposed transaction. Whether a sale, lease, or other transaction/arrangement, please include the following information** - Health Management will acquire the assets and operations via the long term lease excluding working capital and all liabilities. In addition to the $50 million lease payment, Health Management will purchase the inventory at closing.

   a. **Confirmation of the facilities and assets subject to the proposed transaction** - Health Management will acquire through the long term lease the operations, plant, property and equipment, and inventory of BFMC. All other assets will be retained by the Southeast Volusia Hospital District.

   b. **The proposed purchase price for the acquired assets, or the lump sum lease payment if a lease** - $50,000,000 in cash at closing plus the supply inventory valued at closing.

   c. **Assumed liabilities** - Using the proceeds of the lease transaction, the District will pay off all long term debt, capital leases, and interest bearing debt. In addition, it will

provide a financial mechanism to fund any defined pension plans it may currently hold.

d. **Excluded assets** - current assets, investments, retained assets, etc.

e. **Excluded liabilities** - All liabilities will be retained by the Southeastern Volusia Hospital District

f. **Expected post-closing adjustments to the purchase price or lease payment** - No post-closing adjustments to the purchase price are expected, since the District is retaining working capital. The final Asset Purchase Agreement, however, will have customary representations and warrantees with escrow withholds tied to potential material adverse conditions that could occur post transaction.

g. **Other post-closing financial commitments** - None noted at this time, pending due diligence and final agreements.

7. **If the transaction involves a lease, please provide the major terms of such lease, including the following:**

   a. **Term** - 30 years

   b. **Lease payment schedule** - One-time payment of $50,000,000 plus inventory value

   c. **Renewal options** - 30 year renewal with payment determined by Fair Market Valuation

   d. **Other key terms** - To be determined in conjunction with Florida law relative to District Hospitals

   e. **Governance structure** - The new partnership will be a tax paying Florida Limited Liability Company with a Clinical Affiliation Agreement with Orlando Health.

8. **If the transaction is a joint venture partnership, please include the following** - Health Management offers to lease BFMC from the South East Volusia Hospital District, provide permanent Board Seats on the Board of Trustees, and create a clinical affiliation relationship with Orlando Health. If allowable by State law and the District's structure, Health Management will also offer a joint venture relationship, which we believe can be done through the creation of a not-for-profit or for-profit subsidiary of the District.

   a. **Governance structure** - The new structure will be a Florida tax paying LLC with a proposed ownership of 80% Health Management and 20% held by a 501(c)(3) subsidiary of the Southeast Volusia Hospital District. The LLC Board of Directors of eight (8) members will equally govern the partnership with four (4) voting members from Health Management and four (4) voting members from the 501(c)(3).

b. **Ownership percentages for each party as of closing** - At least 20% ownership by the 501(c)(3) and up to 49%

c. **Management arrangement and related fees** - Health Management will manage the partnership under contract and charge 5% of Net Revenue as its professional service fee.

d. **Reserve powers for each party** - Health Management and BFMC will delegate day to management to Health Management via the management agreement and both organizations will govern equally using the following tiers of reserve powers with details to be negotiated in the LLC Operating Agreement. Because it is equally governed there will be potential deadlock situations. As majority owner Health Management will have the right to break deadlocks in majority and major decisions. In the case of a deadlock being broken, BFMC will have the reserve rights to change their ownership position in the LLC.

Given the equal governance status of the LLC Board of Directors, in the event of dead locks on major decisions, Health Management will retain the right to break the deadlock which in turn will give the Bert Fish member minority rights including the ability to change ownership levels or participation. Examples of minority rights in our LLC Operating Agreement include:

General – The Board of Director's will oversee capital contributions, allocation of profit, distribution of free cash flows, and restrictions on transfer of member interests

Majority Decisions – Incurrence of debt or capital expenses over a threshold, granting of liens against property, making loans, creating significant joint venture arrangements, merger or sales of assets, and acquisition or dissolution of assets.

Unanimous Decision Required – Amendment to management agreement, redemption of interest, changing business purpose, change of articles of incorporation, declaration of bankruptcy, change of classification for tax purposes, definition of charity care, distributions other than cash

e. **How future cash distributions and capital expenditures will be calculated and handled** - Per the LLC's operating agreement, the LLC's Board of Director's approves an annual capital spending budget which is funded from operating cash flows. If cash flows are less than expected capital spending then the order of the funding will be:

- Cash flow from operations
- Interest bearing loans from HMA
- Interest bearing loans from non-HMA sources
- Capital calls

The LLC Board of Directors will review and approve will approve all capital related decisions including the annual capital budget, major capital projects beyond the budget, acquisition of other operating entities, joint ventures, debt additions, and debt defeasement.

9. **Provide in-depth management support and systems – clinical, legal, financial, operational, IT, etc.** - Listed below are the services provided through Health Management's Professional Service Agreement:

HMA currently provides the following services from its Corporate Office services to each of its subsidiaries and as a percentage of net revenue averaging 5%. In addition to the professional services fee, HMA also charges the payroll and benefit costs of the Key Management Team (CEO, CFO, CNE, and COO) to the hospital. HMA's Corporate allocation structure and costs are tested annually for fair market value by an independent third-party.

- Budgeting
- Business Office Services
- Capital financing
- Cash Flow management
- Clinical Outcomes
- Compliance
- Construction planning
- Employee benefits
- Executive Management
- Executive Recruitment
- Health Information Services
- HIPAA
- Human Resources
- Legal
- Lobbying
- Malpractice and Liability Insurance
- Managed Care Contracting
- Management Information Services
- Media Relations
- Operational Finance
- Performance Improvement
- Physician Employment
- Physician Practice Management
- Physician Recruitment
- Reimbursement
- Risk Management
- Staffing
- Strategic Planning
- Supply Purchasing

a. **How would the Resulting Organization enhance measurable levels of clinical quality and patient satisfaction** - Health Management leads Florida and the Nation in providing the highest level of Clinical Outcomes with over 64% of our hospitals recently recognized as Top Performers on Key Quality Metrics by The Joint Commission, while only 18% of America's hospitals were recognized on these rankings. We will use our process, resources, and measurements to assist BFMC in also becoming a top performer.

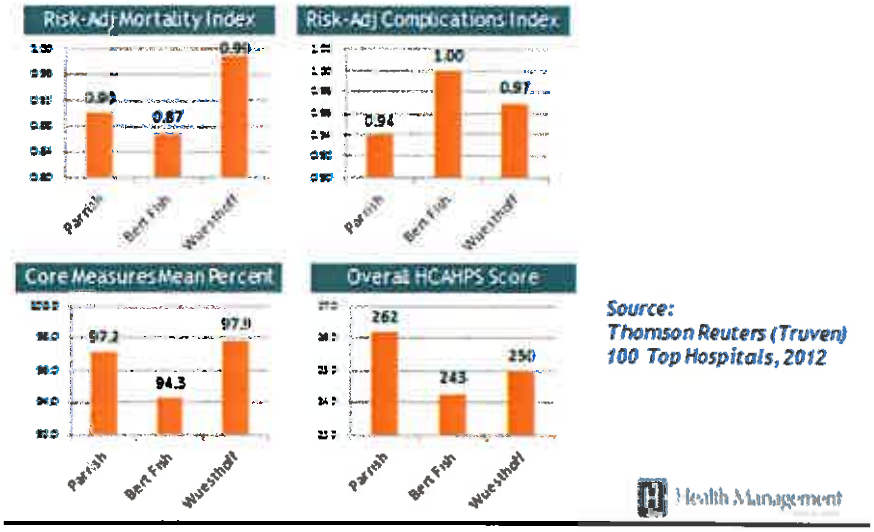
Health Management Recognized as Top Quality Performer by JCAHO

NAPLES, Fla.--(BUSINESS WIRE)--Sep. 19, 2012-- Health Management Associates, Inc. (NYSE: HMA) announced today that 41 of its hospitals were recognized by The Joint Commission as Top Performers on Key Quality Measures in its 2012 report on quality and safety.

These 41 Health Management hospitals were among the 620 hospitals recognized by The Joint Commission, representing the top 18 percent of more than 3,400 Joint Commission accredited hospitals reporting performance data for 2011.

Health Management also uses clinical measurement tools from Thomson Reuters (Nuveen) beyond Medicare Clinical Outcomes to establish benchmarks and improve quality relative to ourselves and competitors. For instance, attached are several benchmarks comparing Bert Fish to HMA's Wuestoff Health System and Parrish Medical Center as measured by Nuveen. As indicated, both Bert Fish and Wuestoff can learn from each other to improve not just clinical outcomes, but safety and customer satisfaction.

Health Care Quality Data



b. **How would the Resulting Organization enhance measurable levels of Hospital's employee and physician recruitment, retention, and satisfaction** - As part of the Getting2Great cultural initiative, Health Management Associates executes a comprehensive customer measurement and improvement strategy for Associate, Physician and Patient perceptions. Health Management utilizes Press Ganey to

conduct Physician and Employee perception surveys then uses the outcomes to improve performance at individual hospitals. Patient surveys are administered continuously while Physician and Associate surveys are administered every 12-18 months. In all areas Health Management falls close to the mean for the Press Ganey database and differs above and below the mean by individual hospital. In addition, a monthly "pulse" survey is administered across the company to monitor Associate perceptions at each hospital. A quarterly "pulse" survey is also administered to monitor physician perceptions.

Annual physician recruiting goals are established and monitored throughout the year for each hospital. A physician on-boarding survey is also administered to any new physician after 90 days of employment/practice within the company.

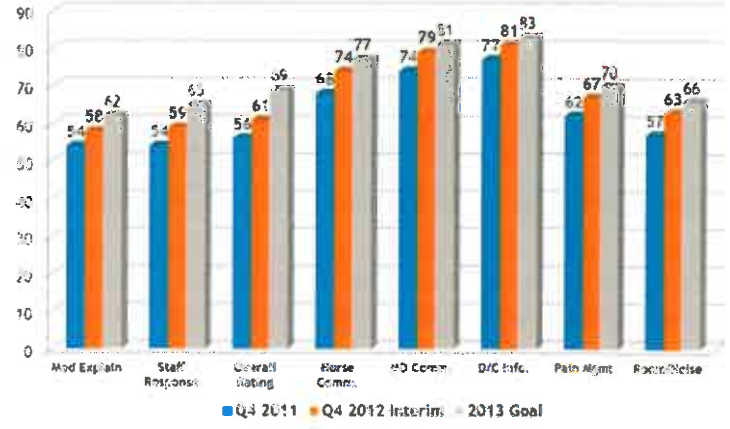
Listed below are customer perception results, trends and projections for Health Management Associates and hospitals within close proximity to Bert Fish Medical Center.

2011 Inpatient/HCAHPS Perception Results

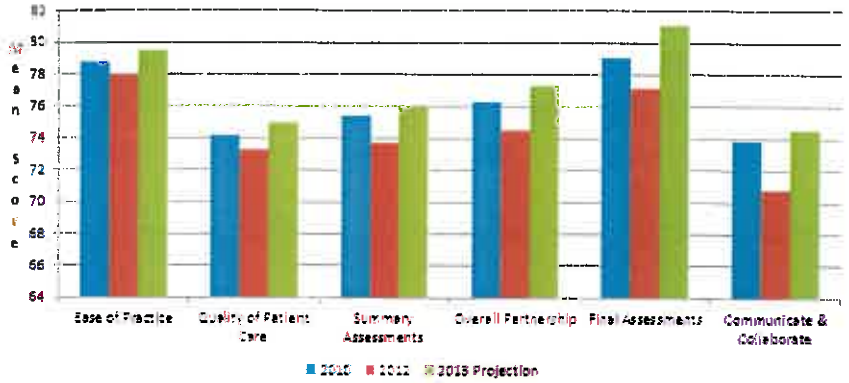
HCAHPS Domain	Sebastian River 2011 % Top Box	Wuesthoff - Rockledge 2011 % Top Box	Wuesthoff - Melbourne 2011 % Top Box	Bert Fish Medical 2011 % Top Box
D/C Information	82	79	74	80
Staff Responsiveness	61	49	46	58
Room/Environment	64	55	60	62
MD Communication	78	70	65	76
Nurse Communication	69	66	65	74
Meds Explained	61	52	54	58
Pain Management	66	62	59	66
Overall Rating (9&10's)	65	44	54	56

*Source: Whynoth thebest.org

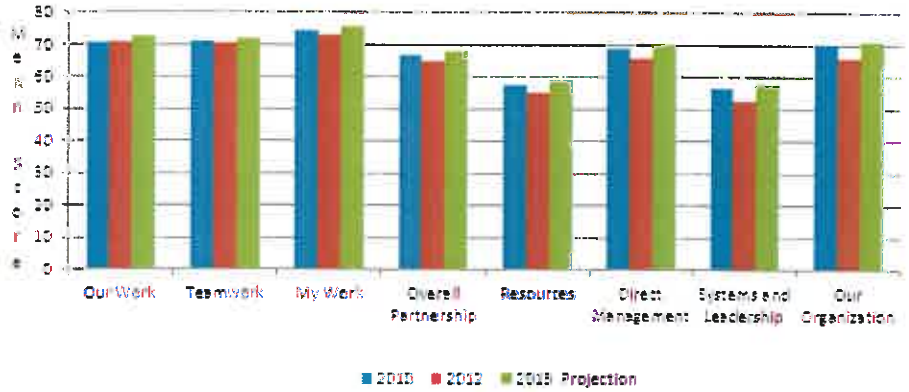
Company-Wide Inpatient/HCAHPS 'Top Box' Perceptions and Projections



Company-Wide Physician Perceptions and Projections

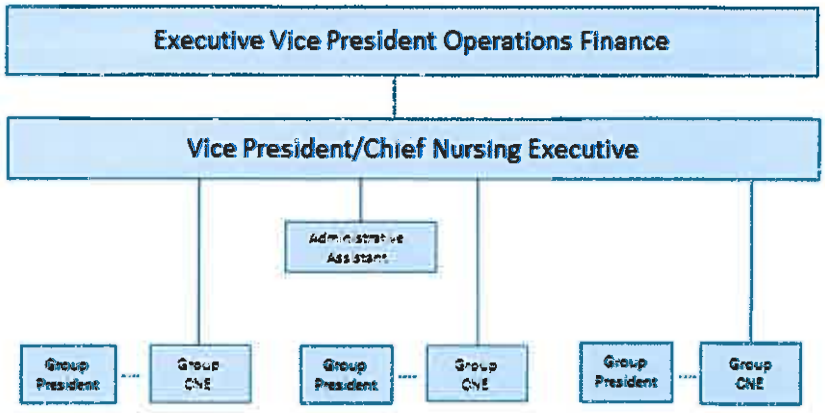


Company-Wide Associate Perceptions and Projections



c. **<u>Please describe and give specific examples of how you will provide continuing education and staff development within the Resulting Organization and the measurable expected benefit to be derived from those programs as they relate to the Hospital</u>** - Health Management continually develops their associates and has wide-ranging capability utilizing existing staff from our 70 hospitals, as well as resources from our corporate office. Through our clinical affiliation with UF / Shands, we provide opportunities for CME in areas ranging from improving clinical quality to new innovation. We provide significant education and re-education in areas of clinical care, utilization management, and competencies. We use technology to provide webinars and other educational programs designed to improve access to educational resources. Our Chief Nursing Executive for the company is currently involved with our corporate Nursing Leadership Council (an organized structure where nursing leaders throughout the company provide input and direction for our clinical programs) in the development of a pilot program to test new ways of nursing care delivery. Our technology team is working with our external innovation vendors to develop enhanced mechanisms for documentation that will completely transform how nurses document, thus giving them more time to actually care for patients. We are a learning organization constantly trying to improve.

Nursing Structure



Vision for Nursing: Perspective from Six Health Management Pillars

- People
  - » Clinical Leader Program
  - » Development of ACNO Program
  - » CNE Orientation and Development
  - » CNE Annual Conference
- Service and Quality
  - » Alignment with disciplines throughout the company to enhance quality outcomes
    - » Nursing leads Corporate Patient Safety Committee
    - » Nursing Sensitive Scorecard
    - » Patient Safety Scorecard
    - » Disseminate best practices through various mechanisms
- Promoting Innovation and Financial Viability
  - » Leading Care Redesign Initiatives (Evidenced-Based)
- Growth
  - » Striving to achieve top scores along all quality and service metrics and using scale to disseminate best practices positioning the organization for continued growth and success

National Nursing Leadership Group: Shared Governance Structure

- The National Nursing Leadership Group is comprised of five staff nurses and five CNE's representative of geographic areas within Health Management, Vice President/CNE, Senior Vice President Human Resources, and Assistant Vice President Human Resources
- Group meets quarterly face-to-face, as well as, conference calls throughout the year

Goals for the National Nursing Leadership Group:

- Visionary planning and focus for nursing advancement throughout the system
- Development/Leadership for clinical nurses through local shared decision making models (Local NLG), in conjunction with PLG
- Focus on initiatives/strategies for clinical nurse satisfaction, such as, Education/Orientation/Competencies essential for all clinical nurses
- Develop, implementation, and dissemination of evidenced-based metrics to include toolkits for enhancement of patient outcomes
- Develop, implement and evaluate Educational Programs that enhance professional development of clinical nurses, such as, Preceptorship Program and Awards & Recognition

Accomplishments System-Wide for Nursing at Health Management through the Nursing Leadership Group:

- System-wide development, implementation, and evaluation of Orientation/Preceptor/Shadowing Program for Clinical Nurses
- System-wide development, implementation, and evaluation of Local Nursing Leadership Council for all hospitals
- Clinical Leader Program

Educational Venues for Nursing

- Annual CNE Conference
- CNE Orientation and Development
- AWHONN Training for Appropriate Staff
- TNCC Certification for Appropriate Staff
- ACLS/PALS Certification for Appropriate Staff
- Clinical and Service Delivery Educational On-line Content
- Webinars throughout the year (i.e. Falls Prevention, Care Redesign)

Health Management Home Office Nursing 2013 Goals

- Develop, implement, and evaluate care redesign delivery model of care
- Develop, implement, and evaluate ACNO program
- Enhance patient and associate satisfaction scores
- Enhance quality outcomes

d. **How will Respondent and the Resulting Organization provide and enhance support for the management team and the clinical staff of the Hospital** - BFMC leadership will report to Health Management's South Florida Division CEO Kathy Burke. Kathy is a Nurse by profession, who has worked in nursing leadership as well as executive leadership in several markets. She leads 12 hospitals and respective markets south of I-4 including Melbourne, Rockledge, Key West, Sebring, Sebastian, Port Charlotte, Punta Gorda, Lehigh Acres, Naples, and Venice. Each market has a unique strategy and business plan driven by the local CEO and Board of Trustees. The role of the Division CEO is to ensure each local management team has the corporate resources and coordination they need in order to achieve their strategic

objectives. Corporate structures are utilized to benchmark performance, and to provide support to the hospital. For instance, if there is a quality of care issue raised, our clinical affairs department deploys a team of experts to assess the issues, make recommendations for corrective action, and then measuring the result to ensure improvement. The ultimate decisions lie with the CEO and Board of Trustees, working collaboratively with the Division CEO, but the corporate resources are contributed so the hospital can benefit from the experience of the larger organization. This is a typical example of how our structures work collaboratively.

10. **Make needed investments in people, facilities and technology** - Health Management proposes to invest at least $15 million in capital spending over the first 5 years following completion of the transaction. Capital spending will include investments in infrastructure, new technology, aesthetics, and acquiring new businesses including ambulatory centers and physician practices. For example, Health Management leads the industry in robotic surgery service placement, especially in smaller and midsized hospitals.

    a. **Please describe the specific commitments your organization agrees to make regarding investment in people/providers, technology and facilities over a five-year period and a ten-year period** - Health Management will invest at least $15 million in all capital spending over the first 5 years and $40 million over a 10 year period. The capital priorities will be driven by an assessment of need at the front end, and by working with the medical staff and Board of Trustees to determine where the greatest need is.

    b. **What portion of the cash flow, before management fee or comparable corporate overhead expense, generated by the Resulting Organization would your organization reinvest in the Hospital and its service area** - Health Management will be re-investing at least $15 million in capital over the first 5 years following completion of the transaction. The investments will be generated from operational cash flows and not new debt. Compared to Bert Fish's 2012 YTD Net Patient Revenues, this amount is over 4% re-investment into the hospital and community. As market share and Net Patient Revenues increase with results from the strategic business plan, the ratios will adjust accordingly, but the overall dollars contributed will increase substantially per year and in aggregate. In addition, Health Management expects to eliminate the need for the tax subsidy for the hospital, so tax payers in the community will be receiving an additional benefit of tax relief of nearly $15 million per year, in addition to the new taxes they will receive from the conversion of the hospital.

11. **Recruit and retain physicians in the community** - Health Management has over 10,000 physician members on the medical staffs of its 70 hospital with 1,200 employed through the Health Management Physician Network. Whether in private practice or employed, Health Management's history and success has come through active partnership with our medical staffs.

a. **How would the Resulting Organization support the Hospital's ability to align effectively with members of its medical staff?** - HMA's Physician Alignment and Provider Network strategies are unique to each market, so we spend considerable time with market executives and physicians from Bert Fish implementing existing programs and adding resources to complement the strategy. As a company we have over 10,000 physicians on our hospital medical staffs nationwide and employ over 1,200 physicians in the Health Management Physician Network. Relative to the Health Management Physician Network in addition to assisting employed physicians, it actively develops and implements MSO services for private physicians in our markets.

b. **Please describe successful physician integration models which have been utilized by your organization or its affiliates, and what model(s) you would suggest be implemented at the Hospital** - As you are aware, 90% of physician offices across the US contain less than five physicians with limited management capabilities to both managed the day to day operations as well stay current with the latest regulatory and payer updates. Health Management currently utilizes an employment model to partner with over 1,332 providers across fifteen states, supporting 70 hospitals. The Health Management Physician Network provides the infrastructure necessary for success physician practice management allowing physicians to focus on clinical excellence. Additionally, the physician network is positioned as a physician friendly network that promotes active physician leadership. Examples include the many physician executive Committees that focus on operational, financial and clinical excellence. This past year, over two hundred physicians donated over 6,000 man-hours to help select a new practice management system and electronic health record. Currently, the physician network consists of key infrastructure that would not be available at such a level to independent physicians which include:

- Full operations support
- Finance and accounting
- Revenue cycle management
- Electronic health record
- Managed care contracting
- Quality management and tracking
- Compliance
- Risk management
- Malpractice coverage
- Human resources
- Marketing
- Business development
- Physician recruiting
- Legal and regulatory support

While the employment model will continue to be a viable option in the future, Health Management is turning its attention towards developing other viable models which is discussed in the next section. Because of a rapidly changing healthcare environment,

coupled with health care reform, there is an opportunity to introduce new models such as an affiliated support model or models that create clinical integration beyond the walls of a hospital or physician office.

c. **How would a relationship with your organization improve the Hospital's ability to recruit physicians?** - Health Management actively recruits more than 1,000 new physicians to our hospitals annually using a combination of Home Office, Group, and hospital resources in conjunction with in house and external recruitment leaders. We will first develop a physician needs assessment with Bert Fish Medical Staff, then implement an action plan to fill those needs in collaboration with the existing medical staff. Our network is extensive. Because of our size, residency programs and medical schools seek to partner with us. We develop pipelines that remain very active, and would lend themselves to Bert Fish should the need for physician recruitment be identified. We always attempt to work with our local medical staff to help them expand their practices, and we also focus on filling gaps in services that are not available locally due to inadequate physician availability. This is a primary driver of our strategy.

d. **What is your approach and track record for strengthening existing community-based private practices as well as the Hospital's owned practices?** - One of the models currently "in the works" is the creation of an affiliated services model that offers support to physicians in independent practices that prefer not to be employed. Health Management is currently developing a three phase approach to introduce a portfolio model of services to independent physicians.

Phase 1 (completed) – Due to the fact that we experience so many physicians with unstable revenue cycle performance and no real plan for an EMR, Health Management contracted with athenahealth via a strategic alliance agreement that allows independent physicians to access athenahealth's practice management system and EMR at greatly reduced pricing while being afforded the same customer service support large heath systems enjoy.

Phase 2 – Currently under development to create a portfolio of thoroughly vetted vendors from key niches to provide greatly missing support to independent physicians. Such services are intended to include medial coding, physician & staff benefit programs, payer credentialing, malpractice underwriting and other day to day support services.

Phase 3 – Phase three will focus on payer contracting and helping assist physicians with navigating healthcare reform under the numerous newly created quality programs.

12. Provide enhanced support for clinical quality and compliance

a. **How would the Resulting Organization enhance measurable levels of clinical quality and patient satisfaction, including successful patient outcomes?**

Quality and Safety

Health Management's goal is to lead the industry in quality at a local and national level. Listed below are example top performance recognitions for Health Management hospitals in Florida and Nationwide. We have a deeply dedicated infrastructure that measures virtually all objective outcomes, and benchmarks those outcomes against industry and Health Management standards. When hospitals fall short, our clinical affairs team focuses resources to assist those hospitals in achieving the quality objectives. This is a constantly moving target as we continue to raise the bar when we meet our standards.

Health Management is ranked 3rd in the Nation on Medicare Clinical outcomes compared to other multi-facility healthcare systems. In addition, Health Management was recognized in September for having 41 of its hospitals named as Top Performers on Key Quality Measures according to a report released earlier today by The Joint Commission, the leading accrediting bodies of health care organizations in America.

From a universe of approximately 3,400 Joint Commission accredited hospitals and critical access hospitals reporting core measure performance data, only 620 hospitals nationwide, or 18% of the evaluated hospitals, earned recognition as top performers In contrast, the 41 Health Management hospitals recognized as top performers represent over 60% of the 70 hospitals Health Management operated throughout the U.S. at the time of the survey.

b. **Please describe and give specific examples of how you provide continuing education and staff development within your organization and the measurable expected benefit to be derived from those programs as it relates to the Hospital** -

Health Management continually develops its associates and has wide-ranging capability utilizing existing staff from our 70 hospitals, as well as resources from our corporate office. Hospital recruitment is primarily done at the local level; however, our corporate office has resources that are continually available to our hospitals. The corporate recruitment staff is responsible for the recruitment of the senior staff at each hospital location. Finally, as part of Health Management's employee benefit package we offer tuition reimbursement as part of the following benefits:

- Health and Dental Insurance and Prescription Drug Plan
- Life Insurance with additional Optional Life Insurance available
- Dependent Life Insurance
- Disability Insurance
- Vision Insurance
- 401K Pension Plan
- Voluntary AFLAC Benefits
- Flexible Spending Accounts (Medical/Dependent Care)
- Sick, Vacation and Holiday Benefits
- Tuition Reimbursement

c. **Please explain how you measure the above** - Health Management utilizes Press Ganey to measure and improve Associate satisfaction for our over 40,000 associates. Although the size, shape, and scope of each hospital is unique to itself, as a large nationwide organization we measure associate satisfaction using tools provided by Press Ganey, but each hospital has a fully functioning Human Resources Department to customize benefits and support at the local level. Overall our total Associate satisfaction for all hospitals is in the 70% range with some facilities performing exceedingly above and some continuing to improve subjective and objective results. In aggregate, each year we target overall satisfaction stretch goals so ultimately as a corporation and at a local level we are the employer of choice.

d. **Please identify what protocols and procedures your organization has in place to ensure compliance by your organization and its affiliates with applicable laws** - At Health Management, our mission is to enable America's best local health care—and, as a growing organization, it is important that we all share the same understanding of how to fulfill this mission. That is why we have a Code. Our Code sets forth the basics of ethical conduct, describing expected behaviors and recommended courses of action for each of us to follow. It does not attempt to describe every possible situation we may encounter—no single document can—but it does offer practical guidance, and points us in the direction of helpful resources, wherever appropriate. In addition to our Code, Health Management maintains a number of detailed policies and procedures that provide further guidance. These policies and procedures can be accessed through our intranet, and are also available through our Human Resources or Compliance Departments. Our Code—along with our Company policies and procedures, our Guiding Principles and the law—sets the foundation for us to be ethical leaders. More than that, it demonstrates to our valued stakeholders our commitment to doing the right thing. Further, the Code is intended

to ensure that we meet our compliance goals in a highly regulated business environment. It is designed to provide general guidance, and does not replace the policies and procedures of the organization. This Code is a "living document," which will be updated periodically to respond to changing conditions. Thus, Health Management reserves the right to modify or terminate any or all of these provisions at any time.

e. **Please describe the extent to which your organization is subject to a corporate integrity agreement, a settlement agreement with a governmental entity or a subpoena which would have an effect on the going-forward operations of the Hospital** - Health Management is not subject to a Corporate Integrity Agreement, nor has it ever been in its history. All public information reflecting regulatory review and all updates are included in Health Management's 10-Qs and 10-Ks including:

HMA has publicly disclosed that it was served subpoenas on May 16, 2011 and July 21, 2011 by the Office of the Inspector General, Department of Health and Human Services. These requested documents, we believe, relate to hospital specific 1) physician contractual relationships, 2) medical necessity of emergency room services, and 3) medical necessity of certain surgical procedures. We further believe that the subpoenas may have originated as a result of qui tam lawsuits filed by individuals.

On February 22 and 24, 2012 HMA publicly disclosed the Office of the Inspector General, Department of Health and Human Services served subpoenas on certain HMA hospitals that have contractual relationships with Allegiance Health Management, a post acute care company unrelated to HMA that provides intensive outpatient psychiatric services. We believe the OIG has served similar subpoenas on other non-Health Management hospitals that had contracts with Allegiance.

Health Management maintains a compliance program operated by an experienced former Special Agent with the FBI, and we have engaged independent outside counsel to conduct an independent review to ensure our continued full compliance. These reviews are being conducted under the direction of the Board of Directors of the company. Each hospital has a compliance officer which reports to the Compliance department, which in turn reports directly to the CEO of the company and the Board. Health Management remains absolutely committed to full compliance, and is fully cooperating with the federal regulators.

13. **Develop and support new clinical programs that meet service area needs** -

a. **Please describe your organization's commitment to provide the Hospital with sufficient investment capital to address the Hospital's investment needs for new clinical programs.** - Health Management intends to spend at least $15 million in capital during the first 5 years. The capital will be spent on existing infrastructure, clinical equipment, aesthetics, and expanding service lines including using a capital budgeting process in conjunction with the Medical Staff and Board of Trustees -

b. **Describe what commitments you would make to assure the Hospital's long-term financial stability and ability to support clinical excellence in the future, including amount and structure of capital, investment, and/or contribution** - The $15 million in capital spending during the first five (5) years will be a contractual obligation itemized in the final Asset Purchase Agreement.

14. **Maintain support of the local economy** - Bert Fish Medical Center is one of the leading employers in Southeastern Volusia County, so it is critical that Health Management not just maintain, but grow healthcare jobs in the area. This is the main reason to select Health Management as its partner since our Mission is to Enable America's Best Local Healthcare by replacing capital, adding services, recruiting physicians, and expanding market share which ultimately adds jobs with a strategic plan to reverse outmigration of patients to Orlando and Daytona.

    a. **How would your organization and the Hospital remain active in the life and fabric of the community, such as with civic organizations, regional planning, and economic development?** -

    Health Management examples of Community Relations – Listed below are examples of community organizations we support in markets throughout the country in addition to local organizations unique to the individual community including Chambers of Commerce, Economic Development Councils, etc.

b. **Please describe the long-term commitment which your organization would make to the District in order to assure the continued operation of the Hospital as an acute care hospital in the community on a going-forward basis** - Health Management will contractually agree to maintain the hospital as an acute care hospital as determined by Florida Statute and Medicare provider standards throughout the duration of the lease.

c. **Please provide the basic outline and resources for your marketing and communication plan for the community, both during any transition and into the future** – Health Management will provide marketing and communication resources from the Naples Home Office in collaboration BFMC's local Marketing and Communication Department.

15. Protect employees of the Hospital

HMA will offer employment to all of BFMC's employees in positions and at Comparable compensation levels provided by BFMC immediately prior to the closing date. HMA shall provide comprehensive employee benefits program that are at least as favorable as those offered by the company to similarly-situated employees at similarly-situated hospitals owned or leased by company. HMA shall credit hired employees with all their employment service (seniority) for BFMC and its affiliates for purposes of determining eligibility for vacation accrual schedules and vesting under all applicable company employee benefit plans and shall provide group health plan coverage and shall impose no greater or additional pre-existing conditions or other eligibility restrictions than apply to any particular employee for the current plan year under BFMC's group health plan. In addition, Health Management will credit employees for those year-to-date health plan deductibles already paid by employees under BFMC's group health plan. Health Management will also prior to the close date conduct around the clock associate information meetings followed by on site individual Benefit enrollment sessions to ensure a seamless transition.

a. **In the event of an integration including the current operations of the Hospital, how would the Resulting Organization preserve existing commitments to current employees of the Hospital?** - HMA will offer employment to all of BFMC's employees in positions and at Comparable compensation levels provided by BFMC immediately prior to the closing date. HMA shall provide comprehensive employee benefits program that are at least as favorable as those offered by the company to similarly-situated employees at similarly-situated hospitals owned or leased by company. HMA shall credit hired employees with all their employment service (seniority) for BFMC and its affiliates for purposes of determining eligibility for vacation accrual schedules and vesting under all applicable company employee benefit plans and shall provide group health plan coverage and shall impose no greater or additional pre-existing conditions or other eligibility restrictions than apply to any particular employee for the current plan year under BFMC's group health plan. In addition, Health Management will credit employees for those year-to-date health plan deductibles already paid by employees under BFMC's group health plan.

Health Management will also prior to the close date conduct around the clock associate information meetings followed by on site individual Benefit enrollment sessions to ensure a seamless transition.

b. **Would your organization support the hiring of all employees in good standing, honoring seniority, and providing substantially equivalent compensation and benefits?** - Health Management will hire all staff employees in good standing at the same rate of pay and retain their current seniority for benefit calculation. Health Management employees over 40,000 associates company-wide providing us considerable purchasing power which will provide Bert Fish associates substantially comparable benefits.

c. **Please explain how you measure the above** - Following selection as exclusive bidder on BFMC, Health Management will meet with its Key Management team to compare benefits and work to customize a local benefit plan so employees are kept whole following the transaction.

d. **How would the Resulting Organization enhance measurable levels of the Hospital's employee and physician recruitment, retention, and satisfaction?** - Employee satisfaction is enhanced through our well-established Getting to Great Program, including the recognition component. Health Management also conducts satisfaction surveys on a regular basis to ensure we are meeting the needs of the associates and physicians. There is also a well-established Nursing Leadership Group that meets quarterly that conducts surveys of the nursing staff and participates in policy development to ensure nursing has the tools required to be successful. Our long standing success of physician recruitment and retention is a result of constant communication and follow up.

16. **Enhance recognition and impact managed care contracting via branding and name awareness** - Health Management's managed care team is focused on providing the best contracting results with local, regional and national payors. We have established long term relationships with national and regional payors. We typically engage in negotiations with payors at the highest levels in their organizations. We anticipate that our national managed care platform would enhance the profile and awareness of Bert Fish across all managed care payors.

    a. **How would the Resulting Organization strengthen the Hospital's market position and enhance community and provider perceptions of its services?** - Being a part of a system of hospitals with the footprint Health Management has in Florida will strengthen Bert Fish considerably. As payment reform happens, it will be important to be affiliated with a system that has the strength to work with leadership in various insurance plans to develop unique payment models that Bert Fish would be unable to do on its own. Also, by expanding services capacity locally, the image of the hospital will improve. We have seen example after example where this model has dramatically changed local perceptions of the hospital. The clinical integration with Orlando Health will provide significant opportunity to invest in

linkages with a tertiary partner, and the linkage to UF / Shands through our existing clinical affiliations will provide opportunity to develop services using the best protocols and access to academic and research capabilities.

b. **Please describe how the Resulting Organization might positively impact payor relationships for the Hospital** - We have ongoing relationships and managed care contracts with payors in all segments (commercial, Medicare Advantage, managed Medicaid). In addition to negotiating pricing with our regional and national payors, we work with payors to establish contracts that streamline operations, clarify contract terms, and help facilitate revenue cycle activities. Through our payor relationships, we are also working on several new programs to align payment and achieve accountability on a value-based approach. Early in 2012, we have established a senior executive team to guide and promote the "Alternative Payment Method" programs that we are negotiating with our payor partners.

17. Required Approvals

a. **Please provide a list of any necessary regulatory, corporate or other approvals required to consummate a transaction, along with a statement indicating your ability to secure such approvals in a timely manner** - The final transaction will require final approval from the Southeast Volusia Hospital District, any Trusts controlling the existing land and buildings, Health Management's Board of Directors, and all local, State, and Federal regulatory approvals. Health Management's experience in the acquisition of over 20 hospitals since 2006 has been full approval in 120 days or less following execution of an exclusive Letter of Intent.

b. **Describe any federal or state limitations that might prohibit you from entering into an arrangement with the District** - None known at this time

18. Liability

a. **Please include a statement acknowledging that neither the District, and Hospital, nor its advisors will be liable to you for any damages or expenses of any kind or type, unless you are the selected Respondent and then, only to the extent set forth in the definitive agreement between the District and the selected Respondent** – Health Management agrees in principle with this statement.

Key points about the "60 Minutes" segment on Health Management

- Our priority, first and foremost, at Health Management is providing top-notch care for patients.

- According to their broadcast, *60 Minutes* conducted more than a year of research and found no issues with the quality of care at Health Management hospitals, stating on the broadcast that "hardly anyone we talked to complained about the quality of care at HMA hospitals."

- It was also notable that *60 Minutes* and even the doctors they interviewed failed to identify a single patient who had been inappropriately admitted from any of the company's emergency rooms, including by them.

- *60 Minutes* did not in any way dispute the admissions data it was provided by Health Management over the last several months. The data showed that admissions rates from the company's emergency room were in line with national norms and consistent over a several year period.

- Instead, *60 Minutes* relied entirely on disgruntled former employees of the company and contracted former physicians, several of whom are seeking financial gain through active litigation with Health Management.

- To be clear, at all Health Management hospitals every decision about whether to admit an emergency room patient to the hospital rests solely with a physician. Similarly, it is a physician or a nurse who decides what tests are appropriate for an ER patient.

- Health Management's hospital administrators do not inject themselves into those decisions. The role of the company's administrators is to provide support for the medical professionals making these clinical decisions, including technology that organizes patient information and helps provide care more effectively.

- Evidence of success came recently when 41 of Health Management's hospitals were named as top performers by The Joint Commission, the federal government's designated rating agency. That's 64 percent of the Health Management hospitals that were evaluated and nearly four times the industry average.

- The credit for Health Management's success belongs to the 40,500 Associates and 10,000 physicians who work hard every day to care for the patients in its hospitals. Health Management, together with its Associates and physicians, looks forward to doing an even better job for patients in the years to come.

Carlisle Regional Medical Center responds to '60 Minutes' segment

The Carlisle Sentinel
December 3, 2012
Stacy Brown

Carlisle Regional Medical Center officials quickly responded to Sunday's "60 Minutes" report that claimed the center participated in Health Management Associates' alleged practice of requiring emergency room doctors to fraudulently admit patients.

"I've been the president of the medical staff three times — and I am hired by the medical staff and not administration — and I can tell you that the culture here has always been that the physicians make the decision (to admit patients)," said Dr. Howard Alster, who has served 26 years as president of the medical staff at CRMC.

"I've never heard a hospitalist complain that they were told they needed to admit or not to admit a patient," Alster continued.

Emergency Room Medical Director Dr. Scott Miekley also said he has never been affiliated with a hospital who had such a practice.

"The meetings we have here at CRMC on a daily basis during the week is to evaluate the performance over all of the emergency room," Miekley said.

"We have a matrix, but none are goals to admit, but we look at length of stay and are we appropriately discharging and admitting. We look more stringently at those patients who return, and we look at whether we may have missed something," Miekley said.

"Here's what we do have," hospital CEO John Kristel said. "We have an environment where both the administration and the medical staff are very passionate about providing high quality care to our patients. We do look at, on a daily basis, how our emergency room is performing," he said.

Statistics provided by CRMC show that the hospital continues to meet or exceed the national average on the majority of process of care measures.

According to Hospital Compare, which is part of the Centers for Medicare & Medicaid Services Hospital Quality Initiative, CRMC met or exceeded national averages in 6 of 8 categories in the "Surgical Care Improvement Process of Care" measures and met or exceeded national averages in 2 of 2 categories in "Pneumonia Process of Care" measures.

Hospital Compare, which uses a variety of tools to help stimulate and support improvements in the quality of care delivered by hospitals, said CRMC was no different than the national average in 3 of 3 "Hospital Readmission Rates Outcome of Care" measures and exceeded the national average in 4 of 8 "Hospital Acquired Conditions" measured.

The overall length of stay in the emergency room at CRMC as of September was 3 hours and 20 minutes, compared to the 5 hours and 30 minutes it logged during the same period in 2011.

Further, CRMC emergency department inpatient admission rates fared favorably to those of other area hospitals.

"To me, each day when I come in to work, I think of myself as a for-quality guy," Kristel said, when asked whether CRMC's status as a for-profit hospital may have played a role in allegations of fraud.

"I walk in here and ask myself whether I helped to improve the quality of care that we're providing for our community," Kristel said.

"The for-profit side doesn't enter my way of thinking. I look at it more as a tax status, that we're paying taxes to our schools and township. We're licensed by the department of health, our physicians are licensed and we're held to the same standards," he said.

While the "60 Minutes" report proved scathing, each of the CRMC officials said unequivocally that any fraud allegations were not true.

"They are absolutely false," Kristel said, adding that the former CRMC doctors interviewed left on their own will and were not asked to leave the hospital.

"I can't get into their heads and tell you what their motives are," Kristel said.

State admission data doesn't back up doctors' claims on '60 Minutes'

The Patriot-News **/PennLive.com**
December 3, 2012
Nick Malawskey (Video Included)

If emergency room doctors employed by the owners of the Carlisle Regional Medical Center are being pressured to admit patients who don't need to be hospitalized, it isn't showing up on state admission data.

Over the last 10 years, the Carlisle Regional Medical Center has had one of the lowest emergency room admission rates in the region, according to state hospital data.

In its report on Sunday, "60 Minutes" interviewed former employees who said the for-profit company — which operates some 70 hospitals nationwide — puts pressure on emergency room doctors to increase admissions.

Carlisle officials have decried the CBS report as inaccurate and false. They said Sunday that admission decisions are based upon need and that the hospital is dedicated to community health — not corporate profits.

Dr. Scott Miekley, the director of Carlisle's Emergency Department, said there was nothing out of the ordinary regarding Carlisle's admission statistics, which he noted are at or below state and regional averages.

Miekley described the report's assertions regarding admissions as "absolutely false" and said in his 20 years of practice he has never been told to admit patients by administrators.

"We don't set up quotas or goals on anything except quality goals," Miekley said. "We're here for quality patient care."

During the "60 Minutes" report, former employees said the system includes admission quotas, which doctors are to meet or be in jeopardy of losing their jobs.

By doing so the hospitals are able to generate a profit, charging patients — and Medicare and Medicaid — for services that are not really necessary.

In Carlisle, the television news program interviewed two former hospital employees, Drs. Clifford Cloonan and Scott Rankin, both of whom worked in the emergency room department.

Cloonan told CBS Correspondent Steve Kroft he was told to admit 20 percent of emergency room patients "or someone would be fired."

"We don't set up quotas or goals on anything except quality goals. We're here for quality patient care." - Dr. Scott Miekley"There's no way you could do that and not be fraudulent," Cloonan told Kroft.

When Kroft asked the two men what was wrong with quotas, Rankin said hospitals "are not building widgets. We're taking care of patients."

In addition to interviews, the news program aired what it said were internal documents from HMA hospitals in other states that indicate doctors were urged to increase admissions. The documents included "scorecards" which were used, the program alleged, to rank doctors.

According to the documents, doctors who admitted less than 20 percent of their patients were viewed unfavorably. Former employees also discussed the system's used of Pro-MED software, which helps a facility evaluate and manage ER patients.

Pro-MED, they said was designed to encourage hospital staff to admit patients, by flagging patients who were scheduled for discharge. It also automatically suggested tests and other procedures based upon a patient's age and medical concerns.

Pro-MED is the subject of an ongoing federal investigation and HMA has discontinued its use.

The HMA official interviewed during the program, Alan Levine, said the allegations were made by disgruntled employees and denied that admission goals were established based upon profit motives, but rather said they were determined by patient need.

In Carlisle's case, state data on emergency room admission rates doesn't corroborate the "60 Minutes" story. According to the state's data, Carlisle has had the lowest admission rate among regional hospitals.

Last year the emergency room admitted 4,183 people out of a total of 30,469 emergency room visits, or roughly 13 percent. During the same time period Holy Spirit admitted 20 percent of its emergency room patients, while the Penn State Milton S. Hershey Medical Center admitted 18 percent.

A 10-year review of admission data shows similar trends.

In 2003, Carlisle reported admitting 17 percent of emergency room visitors — its highest rate since 2001, when HMA bought the center — compared to an 18 percent admission rate at Holy Spirit and 16 percent at the Hershey Medical Center.

TUESDAY, DECEMBER 4, 2012 | YOUR COMMUNITY NEWSPAPER SINCE 1874 | 75¢

Lake City Reporter

LAKECITYREPORTER.COM

2nd medevac provider coming

Airport will have two helicopters in case of major emergency.

By DEREK GILLIAM
dgilliam@lakecityreporter.com

Starting next year, two medevac helicopters will be on standby in Lake City instead of just one.

Lake City Gateway Airport will see the addition of another helipad and another medical crew, along with an additional helicopter to fly the seriously injured to hospitals in the area.

The Lake City City Council on Monday approved a lease agreement with Med-Trans Corp. for the company to fill a vacant property at the airport.

The addition of a second emergency helicopter at the airport will allow for quicker response to major wrecks or other disasters that would require a helicopter for transport to a hospital.

Brian Burrell, regional business director with Med Trans, said the company plans on spending $70,000 to $80,000 before the helicopter will be brought onto the property.

He said the company will bring in a manufactured building to house staff and will pour a new helipad at the airport.

Med Trans will use Trauma One for medical staff, pilots and the engineer, Burrell said. Trauma One was partnered with Air Methods, but the contract with Air Methods ends on Jan. 3.

Toby Witt, regional business manager with Air Methods, said Air Methods has been in Lake City for around 10 years, and that the company will continue to serve the area with medical transport by helicopter.

Air Methods will continue to use the Lake City Gateway Airport, but hasn't released the name of the company that will staff Air Method's helicopter.

HELIPAD continued on 3A

New 'cliff' offer from GOP

ASSOCIATED PRESS

President Barack Obama waves after speaking at the Rodon Group, which manufactures over 95% of the parts for K'NEX Brands toys, on Friday. The visit came as the White House continued a week of public outreach efforts while also attempting to negotiate a deal with congressional leaders.

$2.2 trillion plan includes Medicare age hike

House Republicans make the president a counteroffer.

By ANDREW TAYLOR
Associated Press

WASHINGTON—House Republicans on Monday proposed a new 10-year, $2.2 trillion blueprint to President Barack Obama that calls for increasing the eligibility age for Medicare and lowering cost-of-living hikes for Social Security benefits.

The proposal from House Speaker John Boehner, R-Ohio, and other Republicans comes in response to Obama's offer last week to hike taxes by $1.6 trillion over the coming decade but largely exempt Medicare and Social Security from budget cuts.

The GOP plan also proposes to raise $800 billion in higher tax revenue over the decade but it would keep the Bush-era tax cuts — including those for wealthier earners targeted by Obama — in place for now.

Boehner said the GOP proposal is a "credible plan" for Obama and that he hopes the administration would "respond in a timely and responsible way." The offer comes after the administration urged Republicans to detail their proposal to cut popular benefits programs like Medicare, Social Security and Medicaid.

"After the election I offered to speed this up by putting revenue on the table and unfortunately the White House responded with their in-kind offer that couldn't pass the House, couldn't pass the Senate and it was basically the president's budget from last

CLIFF continued on 3A

Berry: '60 Minutes' allegations don't apply here

By DEREK GILLIAM
dgilliam@lakecityreporter.com

Health Management Associates, a nationwide chain that operates Shands Lake Shore Regional Medical Center and two other hospitals in North Central Florida, was the subject of a "60 Minutes" report Sunday that claimed the company in some cases pressured doctors to admit patients regardless of medical need.

HMA operates 70 hospitals nationwide and 22 in Florida, including Shands Lake Shore, Shands Live Oak Regional Medical Center and Shands Starke Regional Medical Center. One of the hospitals where such activity allegedly occurred was in Pennsylvania. No mention was made in the report of HMA facilities in Florida.

HMA continued on 3A

Shands Lake Shore is one of 70 hospitals owned by Health Management Associates, which was accused by "60 Minutes" Sunday of admitting ER patients who did not require hospitalization in some of its facilities.

Rangers keeping eyes on the sky

Without rainfall, risk of wildfire will rise in winter.

By TONY BRITT
tbritt@lakecityreporter.com

Florida Forest Service officials said wildfire activity in November was at a minimum level, and indicated they aren't expecting a recurrence of severe to extreme drought conditions, even though local rainfall levels are below normal.

According to statistics from the Suwannee Forestry Center, there were only 15 fires in the district's six county area and those fires burned a total of 15 acres. The Suwannee Forestry Center covers wildfires in Baker, Bradford, Columbia, Hamilton, Suwannee and Union counties.

In Columbia County there were only three fires reported in November that burned approximately five acres. The 2012 Columbia County totals indicate there has been 45 fires which burned 3,336 acres. In the district there has been a total of 235 fires that burned 4,146 acres.

Kurt Wiener, Florida Forest Service

FIRE continued on 3A

Econ board to review projects

By TONY BRITT
tbritt@lakecityreporter.com

The Columbia County Economic Development department is experiencing an increase in project activity and according to department officials, has been involved in seven projects over the past two months.

Jesse Quillen, Columbia County Economic Development Department executive director, will discuss the activity during the department's board meeting at 4 p.m. Wednesday at the Lake Shore Hospital Authority conference room 259 NE Franklin St., Suite 102.

Quillen will discuss the projects during his monthly department report at the meeting.

According to documents from the economic

PROJECTS continued on 3A

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COMING WEDNESDAY
Local news round-up

CLIFF: GOP proposal includes more revenue

Continued From Page 1A

February," Boehner told reporters.

The Boehner proposal revives a host of ideas from failed talks with Obama in the summer of 2011. Then, Obama was willing to discuss politically controversial ideas like raising the eligibility age for Medicare, implementing a new inflation adjustment for Social Security cost-of-living adjustments and requiring wealthier Medicare recipients to pay more for their benefits.

On Monday, Obama did not respond to questions from reporters on his reaction to the Republican counteroffer or whether he had seen the proposal.

The clock is ticking closer to the end-of-year deadline to avert the fiscal cliff, which is a combination of the expiration of Bush-era tax cuts and automatic, across-the-board spending cuts that are the result of prior failures of Congress and Obama to make a budget deal.

Many economists say such a one-two punch could send the fragile economy back into recession.

GOP aides said the plan was based on a plan floated by Erskine Bowles in testimony to the special deficit "supercommittee" last year — in effect a milder version of the highly controversial 2010 Bowles proposal that caused both GOP and Democratic leaders in Congress to recoil.

By GOP math, the plan would produce $2.2 trillion in saving over the coming decade: $800 billion in higher taxes, $600 billion in savings from costly health care programs like Medicare, $300 billion from other proposals like forcing federal workers to contribute more toward their pensions, and $300 billion in additional savings from the Pentagon budget and domestic programs funded by Congress each year.

Under the administration's math, GOP aides said, the plan represents $4.6 trillion in 10-year savings. That estimate accounts for earlier cuts enacted during last year's showdown over lifting the government's borrowing cap and also factors in war savings and lower interest payments on the $16.4 trillion national debt.

Last week, the White House delivered in Capitol Hill its opening proposal: $1.6 trillion in higher taxes over a decade, a possible extension of the temporary Social Security payroll tax cut and heightened presidential power to raise the national debt limit.

In exchange, the president would back $600 billion in spending cuts, including $350 billion from Medicare and other health programs. But he also wants $200 billion in new spending for jobless benefits, public works projects and aid for struggling homeowners. His proposal for raising the ceiling on government borrowing would make it virtually impossible for Congress to block him going forward.

Republicans said they responded in closed-door meetings with laughter and disbelief.

The GOP plan is certain to whip up opposition from Democrats opposed to any action now on Social Security, whose defenders say should not be part of any fiscal cliff deal. And Democrats also are deeply skeptical of raising the Medicare age.

Both ideas were part of negotiations between Boehner and Obama in the summer of last year.

In a letter to the president, Boehner and six other House Republicans insisted that the November election that returned Obama to the White House and the GOP to majority control in the House requires both parties to come together "on a fair middle ground."

"With the fiscal cliff nearing, our priority remains finding a reasonable solution that can pass both the House and Senate, and be signed into law in the next couple of weeks," Republicans wrote.

CDC: Flu season starts early, could be bad one

Associated Press

NEW YORK — Flu season in the U.S. is off to its earliest start in nearly a decade — and it could be a bad one.

Health officials on Monday said suspected flu cases have jumped in five Southern states, and the primary strain circulating tends to make people sicker than other types. It is particularly hard on the elderly.

"It looks like it's shaping up to be a bad flu season, but only time will tell," said Dr. Thomas Frieden, director of the Centers for Disease Control and Prevention.

The good news is that the nation seems fairly well prepared, Frieden said. More than a third of Americans have been vaccinated, and the vaccine formulated for this year is well-matched to the strains of the virus seen so far, CDC officials said.

Higher than normal reports of flu have come in from Alabama, Louisiana, Mississippi, Tennessee and Texas.

HELIPAD: Quicker service

Continued From Page 1A

Area residents will receive better service with two helicopters located at the city's airport, Witt said.

"We've got medical staff hired, and we're ready to go Jan. 3," Witt said.

He said the medical staff, along with pilots and engineers, have been identified, but that the company hasn't given permission to be named yet.

Burrell said Med-Trans plans on being ready Jan. 3, and will be able to start work sometime in the middle of December.

"We're going to be moving quick," he said. "A lot of work to be done."

In other business:

•The city approved a "token of appreciation" of $50 for part-time employees and a $100 for full-time employees. The cost will be around $24,000. City Manager Wendell Johnson said the city should recognize the work that city employees do.

•The Lake City Fire Department eliminated three battalion chief positions and reclassified the position to firefighter. The move will save the city about $65,000 a year. There are currently two battalion chief positions filled by the city, but one of the battalion chiefs is a candidate to for assistant fire chief and the other will be retiring. Interim Fire Chief Frank Armijo said.

PROJECTS: Hundreds of jobs could result

Continued From Page 1A

development department, since October the EDD has participated in seven projects that collectively represent close to half a billion dollars of investment and more than 1,000 potential jobs.

"It's really for education purposes to tell them (board members) what's coming our way," Quillen said. "With these opportunities, some we've been able to compete on and some we've have not. I'm trying to help my board and folks understand over time what it really takes to be competitive.

"Some of those projects require buildings that we may not have and some of them may require locations that are out of our control. There are all kinds of criteria that different projects demand that won't allow us to compete."

Quillen said he added the information to his monthly report in order to share the information with others about the activity the economic development department has experienced.

"Hopefully we are competing for a good number of those seven projects not all of them, but out of the ones we are competing on, if we could do one or two of those projects, that would be wonderful," he said. "We're getting some good looks."

The seven projects were listed under code names, as allowed under Florida law. The projects include:

- Project Redwood, a distribution center, potentially creating 500 jobs.
- Site Selection, a call center survey.
- Project Reach, a call center, potentially creating 150 jobs.
- Project Spark, a manufacturing company, potentially creating 400 jobs.
- Project Century, food manufacturing; potentially creating 50 jobs.
- Project Bark, a wood pellet facility, potentially creating 80 jobs, and
- Project MegaSite, Original Equipment Manufacturing no details on potential job creations.

In addition, David Ramsey, Gainesville Council for Economic Outreach vice president, is scheduled to be a guest speaker at the meeting.

Quillen said Ramsey is entrepreneurship and innovation is a big focus of the Gainesville Chamber of Commerce.

"The underlying theme there and the reason for having Ramsey here is build the relationship with Gainesville so that we understand fully what they're doing and trying to figure out ways that we can take advantage of activity that they have down there," Quillen said.

FIRE: 15 blazes reported in area in November

Continued From Page 1A

mitigation specialist and public information officer at the Suwannee Forestry Center, said the local wildfire activity reported during November is within normal limits.

However, he noted that the area is in the midst of a rainfall deficit.

"We have a rainfall deficit now in our six-county area," he said. "Generally speaking it's about 2 -3 inches, but there are a couple of spots where it may be up to four inches."

The National Interagency Fire Center Office of Predictive Services is forecasting normal temperature and precipitation levels from December March with average wildfire potential.

"Although the forecasts sound comforting, we cannot ignore the possibility of serious fire risk," Wisner said. "We have not had significant rainfall in over the past two months.

"We're already seeing counties to our west, out in the Panhandle, drilling back into having an abnormally dry drought situation," Wisner continued. "We don't foresee that drought, within the next three months or so, is going to be a problem like it was many months ago when we had exceptional drought throughout our area."

Wisner said the importance is not the amount of the deficit, but that there is a deficit.

"Many people in our area don't realize there is a rainfall deficit, because there are still people trying to recover from Tropical Storm Debby flooding and they are probably very relieved there is no rain falling on them right now," he said. "From the perspective with what's happening with the forest fuels — grasses and vegetation which we look at as fuels for fires — we have to look at it as things are getting more dry and when things start to get more dry we have a propensity to have wildfires."

Wisner said recent frosts have cured surface fuels, making them more volatile and noted lower humidity levels and gusty winds will increase wildfire potential.

"Under dry, windy conditions dried grasses will ignite easily and fire will spread quickly," he said. "The area through all of North Florida is drying out and when it dries out that gives us a pretty good fire risk."

Although Florida Forest Service officials are granting some controlled burn permits, Wisner suggested residents check with forestry officials before setting any fires.

"It's a day-to-day call especially this time of the year," he said, describing fire activity. "The weather and atmospheric conditions really vary widely this time of the year. Residents should check on the weather conditions daily."

HMA: 'Baseless,' local official says

While the "60 Minutes" investigation didn't allege poor care for patients at hospitals owned by the company, the report did suggest that supervisors at some hospitals set quotas for doctors to meet for emergency room inpatient services. Inpatient services are typically more expensive, and profitable for a hospital compared to outpatient observation.

Jack Berry, executive director of Lake Shore Hospital Authority, which leases the land where Shands Lake Shore operates, said he watched the report and thinks the allegations are baseless.

"I saw it, heard it and none of it is true about our hospital as far as I know," he said.

Rhonda Sherrod, market chief executive officer for Shands Lake Shore, declined comment, but Market Director Linda Silecchia sent an email with the company's official response.

In the response, HMA said the company sent admissions data that demonstrated the company's hospitals emergency room admissions rates "were in line with national norms and consistent over a several-year period."

The company said "60 Minutes" relied entirely on disgruntled former employees of the company and former contracted physicians, several of whom are seeking financial gain through active litigation with Health Management (Associates)."

Furthermore, "'60 Minutes' failed to identify a single patient who had been inappropriately admitted from any of the company's emergency rooms, including by the physicians interviewed."

In a Nov. 30 conference call anticipating the airing of the segment on "60 Minutes," Eric Waller, HMA senior vice president and chief marketing officer, said the company's emergency room admission rate was 13.3 percent.

Waller went on to say that the company's emergency room admission rate for Medicare patients had decreased from 36.4 percent to 34.4 percent.

"Again these are in line with the national norms," he said in a prepared statement. "No statistical significance."

HMA: '60 Minutes' report on health care corporation skewed

Naples Daily News

December 4, 2012

Liz Freeman

NAPLES — Health Management Associates Inc. commented Monday on a report regarding the company on the television program "60 Minutes."

"60 Minutes," according to its report, conducted more than a year of research and found no issues with the quality of care at Health Management hospitals, stating on the broadcast that "hardly anyone we talked to complained about the quality of care at HMA hospitals," HMA said in a statement.

And, "60 Minutes" failed to identify a single patient who had been inappropriately admitted from any of the company's emergency rooms, including by the physicians interviewed, HMA said. Neither "60 Minutes" nor the physicians interviewed identified any admission decision in which a physician's medical judgment was overridden by an HMA executive, much less to defraud Medicare.

HMA contended that "60 Minutes" did not in any way dispute the admissions data it was provided by Health Management over the last several months. That data demonstrated that admissions rates from the company's emergency rooms were in-line with national norms and consistent over a several year period.

Instead, "60 Minutes" relied entirely on disgruntled former employees of the company and former contracted physicians, several of whom are seeking financial gain through active litigation with Health Management, HMA officials said in a statement.

On Nov. 30, just after being notified that "60 Minutes" was moving forward with its broadcast, Health Management held a conference call in which it provided key data about admissions from its emergency rooms. HMA officials said the information presented on the call, and additional information added since the program's airing, are instructive about the "60 Minutes" segment and available for viewing on the Investor Relations section of HMA.com.

"Health Management enables America's best local health care by providing the people, processes, capital and expertise necessary for its hospital and physician partners to fulfill their local missions of delivering superior health care services. Health Management, through its subsidiaries, operates 70 hospitals with approximately 10,500 licensed beds in non-urban communities located throughout the United States," HMA said Monday.

Hospital ER Director Disputes '60 Minutes' Report

Times Record (Fort Smith, Arkansas)
December 5, 2012
Rusty Garrett

A segment on CBS television network's news program "60 Minutes" claiming Health Management Associates Inc. — owner of Sparks Medical Center in Fort Smith and Summit Medical Center in Van Buren — has been pressuring emergency-room physicians to increase the admission of Medicare patients got it wrong, the head of the hospitals' emergency departments said Tuesday.

Dr. Lee Johnson, ER medical director at Sparks for 10 years and for both hospitals over the past year, said contrary to statements former HMA physicians made on the network television broadcast, the company does not establish quotas for admitting patients and does not rate physicians on how many patients they may admit for inpatient treatment.

Johnson said any tracking of emergency patients' subsequent admissions is performed to detect patterns in ER treatment and admissions.

"We assume if we see the same population we ought to be admitting about the same percentage of patients," he said. "If we begin to see a physician is admitting less or more in numbers outside the normal practice, that might raise concern. But as far as tracking with a goal, or meeting a goal, we've never felt pressured to do that."

"In my experience at my experience at Sparks, HMA has been a positive partner in our treatment of patients," Johnson said. "I've never been pressured to do anything that is not clinically sound." He also said assertions in the segment that patients are admitted to make the hospitals more money "is hard for me to swallow."

Johnson said insurance and government regulators scrutinize claims and those found to be unjustified are not allowed.

"The truth is if they admit inappropriate claims they're going to lose money," he said, "whether the patient is admitted or not."

HMA corporate officials also commented on the Sunday night broadcast.

In a statement issued Monday, HMA said, "… '60 Minutes' relied entirely on disgruntled former employees of the company and former contracted physicians, several of whom are seeking financial gain through active litigation with Health Management."

One portion of the segment featured comments by Dr. Jeffrey Hamby, a Van Buren physician who worked for EmCare, a provider of services under contract to Summit's emergency room. Hamby has filed a suit against Summit alleging wrongful termination.

HMA also noted "60 Minutes" "found no issues with the quality of care at Health Management hospitals" and that the news program "failed to identify a single patient who had been inappropriately admitted from any of the company's emergency rooms by the physicians interviewed."

"Neither '60 Minutes' nor the physicians interviewed identified any admission decision in which a physician's medical judgment was overridden by an HMA executive, much less to defraud Medicare," HMA also stated.

On Friday, after being notified that "60 Minutes" was moving forward with its broadcast, Health Management held a conference call in which it provided data about admissions from its emergency rooms.

Alan Levine, HMA senior vice president and Florida group president, said in the call the data showed the company's admission rates from 2008-11 "remain consistent and completely in line with industry norms. We have seen no evidence of upward trends, spikes or jumps that can be attributed to anything going on in the emergency department."

The information presented on the call and additional information is available in the Investor Relations section of HMA.com.

HMA's stock, traded on the New York Stock Exchange under the symbol HMA, has fallen in value since the "60 Minutes" segment aired. The stock was trading at $8.07 per share Thursday and closed at $7.95 per share Friday. Monday it opened at $7.69. At the close of trade Tuesday, it was valued at $7.37.

MEDICAL CENTER
of Southeastern Oklahoma

A SAD DAY FOR JOURNALISTIC INTEGRITY

The recent 60 Minutes segment alleging that Emergency Room physicians are asked, even pressured, into admitting Medicare patients by Health Management Associates was completely off mark and, while I would normally simply ignore such a biased story, I feel compelled to defend my profession! What I find most offensive is the implication that my integrity and my commitment to providing the best possible medical care to my patients is somehow malleable. The thousands of nurses, doctors and mid-level providers who work in hospitals across the nation, providing vital services for their communities, should likewise be offended. CBS should be ashamed of this one-sided storyline thrown together and only offering statements made by a group of disgruntled terminated employees without any input from those of us in the trenches at HMA facilities.

As an Emergency Room Medical Director who has worked at the same HMA hospital for 25 years I can say, unequivocally, that I have never been asked to admit any patient to my hospital in order to meet any established goals or quotas. I am not, nor have I ever been, employed by HMA. As Medical Director I understand that evaluating performance (as with most professions) is a valuable tool. We use a number of metrics for this evaluation; including length of stay, time to exam, patients who leave without treatment and patients leaving against medical advice, to evaluate the performance of all physicians. All are valid criteria in the evaluation of a physician's performance. However, admissions are NOT used as criteria to evaluate the performance of any physician nor have admissions ever been a part of that criteria.

An additional important point that 60 Minutes failed to make is that Emergency Room Physicians actually DO NOT admit any patients to the hospital. The decision to admit or discharge a patient is made by the patient's attending physician after consultation with the ER physician. That decision rests solely with the attending physician.

I am proud to say, that in these past 25 years of my practice, HMA truly has been a partner in our community, providing our physicians with the necessary tools to deliver top notch quality care to the patients we treat.

James D. Ford, DO
Medical Director Emergency Department
Medical Center of Southeastern Oklahoma
Durant, OK. 74701

THOMSON REUTERS STREETEVENTS

EDITED TRANSCRIPT

HMA - Health Management Associates, Inc. to Discuss Impending 60 Minutes Segment Conference Call

EVENT DATE/TIME: NOVEMBER 30, 2012 / 2:00PM GMT

OVERVIEW:

HMA discussed about impending 60 Minutes segment.

CORPORATE PARTICIPANTS

John Merriwether *Health Management Associates Inc - VP of Financial Relations*

Alan Levine *Health Management Associates Inc - SVP, Florida Group President*

Eric Waller *Health Management Associates Inc - SVP and Chief Marketing Officer*

PRESENTATION

Operator

Good morning. My name is Rob, and I will be your conference operator today. At this time, I would like to welcome everyone to the Health Management comments on impending 60 Minutes segment conference call. All lines have been placed on mute to prevent any background noise.

(Operator Instructions)

Thank you. Mr. John Merriwether, you may begin your conference.

John Merriwether - *Health Management Associates Inc - VP of Financial Relations*

Thank you, Rob. Good morning everyone. We apologize for the technical difficulties and getting the call started a little late. I think we have everything ready to go. I'd like to welcome you to Health Management's conference call. We anticipate this call to be brief.

As you may recall, in July, we first called your attention to a local newspaper report on our Pennsylvania market saying that 60 Minutes was interviewing emergency physicians who formerly worked at some of our hospitals. At the time, we noted that a producer for 60 Minutes was soliciting contact from physicians through the American Academy of Emergency Medicines website. Yesterday, at approximately 5.30 PM Eastern Time, we received notification from the executive editor CBS's 60 Minutes that they intended to broadcast a story related to Health Management on Sunday, December 2.

Given that 60 Minutes has not released any indication on its website of the airing the story, we continue to have no certainty about the exact contents of the story, although we have been able to gather certain information about the themes of the story, based on our interactions with 60 Minutes. That said, we wanted to share some details with you about the operation of the Company's emergency departments. We appreciate everyone rearranging their schedule to be with us on such short notice.

Before we get started with the call, I'd like to read our disclosure statement. Statements made in this presentation are based on current estimates of future events and the Company has no obligation to update or correct these estimates. Listeners are cautioned that any such forward-looking statements are not guarantees of future performance and involve risks and uncertainties that our actual results may differ materially as a result of these various factors. Additional disclosure statements accompany the data charts that have been provided for the call this morning at 8.50 AM Eastern time.

Presenting with me on the call today are Alan Levine, Senior Vice President and Florida Group President, and Eric Waller, Senior Vice President and Chief Marketing Officer. Now, let me introduce Alan Levine. Prior to assuming his role with Health Management, Alan was Secretary of Health for both Florida and Louisiana. In those capacities, led efforts to fight Medicaid fraud. For the past few months, we've attempted to cooperate with 60 Minutes to provide information and answer their questions. Further, Health Management provided an on camera interview with Alan on October 8, 2012.

Alan Levine - *Health Management Associates Inc - SVP, Florida Group President*

Thank you, John. Good morning.

First, I'd like to reiterate what John said in that at this point, we do not know for certain what specifically will be in the story, other than what we can surmise from the questions I was asked during my interview with 60 Minutes. That having been said, we do want to take some time this morning to share with you what we do know, and to discuss our emergency room operation.

At Health Management, it is our commitment to remain focused, first and foremost, on doing what is right for our patients. If we do this, and we do, we believe our hospitals and our company will thrive, as we have. This strategy is proving results, as evidenced by the fact of the joint commission named 41 of our then 65 hospitals as top performers in the United States for 2011, which is a rate four times the national norm. It is a recognition earned by only 18% of hospitals nationally.

Fortune magazine named Health Management one of the worlds most admired companies in health care, including ranking us number one in social responsibility, and number one in quality of product and service. Company wide, our hospitals compiled a score above 98 out of 100 for adherence to core measures, process of care measures that are tracked by the centers for Medicare and Medicaid services. Our scores are among the leading scorers in the industry. These results happen because we do measure what we do. We are focused on providing the best processes of care for our patients and the results do show.

We expect our physicians, more than 10,000 affiliated and contracted physicians throughout the United States, to consistently provide high-quality care for our patients by adhering to evidence-based practices in the exercising of their outstanding medical skills. Patients are admitted from emergency departments only, only by primary care doctors, hospitalists, or specialists exercising their independent medical judgment, and working in consultation with our ER doctors. Simply put, administrators cannot and do not admit patients.

In providing the highest quality care possible for our patients, we also strive every day to operate with the highest ethical standards and in compliance with the heavy, heavy regulatory requirements of our Business. We have a comprehensive compliance program that seeks to assure that the laws are clearly understood and followed. When any employee, doctor, patient, member of the community or anyone raises complaints or concerns about our Company or about our hospitals, we endeavor to fully investigate the concern and rectify any issues that are uncovered.

As I said, 60 Minutes' questions to me focused on admissions through our emergency rooms in the general time period of late 2008 through 2011. An analysis of our admissions data by a third-party expert shows that during that time period, the admissions rates through Health Management's emergency rooms remain consistent and completely in line with industry norms. We have seen no evidence of upward trends, spikes our jumps that can be attributed to anything going on in the emergency department. Given the hard data, we remain uncertain about what to expect from the 60 Minutes story.

Just to repeat, emergency room admissions data across our hospitals reflects no significant change, and are in line with industry norms. We will discuss the admission data points with you in a moment, and provide background on the analytics firm that conducted this review for us.

Based on the questions asked of me during my interview with 60 minutes, let me discuss some of the areas I expect that they may cover in their report. While I hope the story is an accurate reflection of the challenges faced by our industry covering topics like, number one, over utilization of observation status classification for patients who should be classified as inpatients. And two, the pressures created on our hospitals by the recovery audit contractor process. I understand that such topics do not make for sensational news. In fact, we could spend days discussing the policy nuances of hospital operation and how these policies are impacting hospitals throughout the United States.

Given that, I would relay to you that I did my best to educate 60 Minutes about the topics they raised. The reality is, as the American Hospital Association has clearly articulated in their lawsuit against CMS, and in the public comments issued by the American Hospital Association, and as the center for Medicare advocacy has stated in their class-action suit against CMS on behalf of senior citizens, Medicare beneficiaries are being severely impacted and hospitals struggle with how to manage these patients between observation and inpatient status under threat of serious financial consequences or even inappropriate allegations related to admission.

Again, I refer you to the AHA lawsuit for specific examples. I'd also refer you to the study recently conducted by Brown University, which is perhaps one of the best examples of how this shift is occurring. One of the hospitals cited, incidentally, in the American Hospital lawsuit is a neighboring hospital to Carlisle Regional and is not affiliated with Health Management.

All told, I was asked extensive questions about whether Health Management has excessive admissions from our emergency departments. We do not. Further, we provided 60 Minutes with hard data from the government to support it. I was also asked about hospital testing protocols. We follow recommendations made by the American College of Emergency Physicians related to triage-based testing. Our hospital medical staff's determine what testing is done, and we measure our process of care results everyday to make sure we see patients timely, provide an accurate diagnosis, and get care provided appropriately.

Since we take these matters so seriously, we have been conducting an extensive review and internal investigation since we first became aware of certain allegations, including those raised, we think, being raised by 60 minutes. We have retained some of the top experts in the United States to examine our practices, guide our internal investigation, and evaluate our data. We looked at the data on our admissions from both the ER and the number of tests ordered for emergency patients, both at the hospital and company levels. Health Management's review shows there is no basis for an allegation that admissions through our emergency departments increased or are not in line with the industry standards.

This morning we have posted the results of the relevant data analysis on our website and we would encourage you to review it. You can access this data by visiting the Company website at hma.com, where you will see a button entitled ER admissions data. This button also resides on the Investor Relations page.

While we do not know for sure, 60 Minutes did inquire about several former Health Management employees, including some with pending litigations against our Company. As always, we will not comment about pending litigation and those matters will be handled appropriately, not in the media but in the courts. Also, we sincerely hope that 60 Minutes has the journalistic integrity to thoroughly investigate any claims or statements to assure that inaccurate allegations are not aired inappropriately by CBS.

Once again, what our experts have determined was that the admissions data simply does not support any allegation that Health Management's emergency rooms were operated inappropriately. Our performance on these metrics is in line with national averages, and our individual hospitals are in line with local competitors. Eric Waller will have more to say about our data and other research in just a few minutes.

Our industry faces serious concerns related to our regulatory environment. We have discussed many of these topics in detail with 60 Minutes, and we hope they will address subjects like the proper classification of patients, including the lawsuit filed against CMS by the American Hospital Association and a class action filed against CMS by the Center for Medicare Advocacy. These very lawsuits evidence that hospitals throughout the nation and Medicare beneficiaries are faced with serious challenges related to the issue of observation and inpatient. Frankly, we don't understand how any story that discusses admission processes in the ER can be a fair story unless it also appropriately tells the story that the industry is facing with the proper management of patients in the ER related to inpatient and observation status.

These are the last three-points I want to emphasize. Number one, our focus has been and is now always on our patients. As long as we continue to do the right thing for our patients, which means providing the highest quality health care that we can, success will follow.

Number two, we our proud of the work our almost 45,000 employees and 10,000 affiliated staffed physicians do everyday to ensure the safety and well-being of our patients. Third, it is our goal to not only meet, but exceed regulatory requirements by doing the right thing and providing the best care possible for patients.

The joint commission is the agency that accredits hospitals on behalf of the Federal Government, and the federal governments own accreditation not agency has highlighted our hospitals as one of the top performing in the United States. The bottom line is if we do misstep, we are fully committed to remedying any errors and improving our processes to make sure it does not happen again. That's what you would expect from any responsible company.

True to our mission to enable America's best local healthcare. Our work often is what ensures our communities have a local hospital at all so patients can get the care they need close to home. Fulfilling that mission is the basis of all of our success clinically, operational, and financially. Now I will turn it back to John.

John Merriwether - *Health Management Associates Inc - VP of Financial Relations*

Thanks, Alan. I would now like to introduce Eric.

As you may recall, Eric have a presentation at our 2011 Investor Day on the analytics capabilities that we are developing. Our leading edge use of the massive amounts of data we collect at our 70 hospitals helps us recognize patterns in our Company's patient data to predict the clinical needs of our communities, potential for readmission rates, demand for services and staffing needs. Eric has led this and many other important initiatives for the Company since he joined us in 2009. He will now take us through the research the Company conducted, including the data that undercuts the assertions that we believe 60 Minutes plans to report on.

Eric Waller - *Health Management Associates Inc - SVP and Chief Marketing Officer*

I will keep this brief. First of all, thank you all for coming. As Alan has communicated, we take this very, very seriously. What we did is we undertook an analytic, unemotional, unbiased effort to try to get at is there anything in the data that would indicate any of the allegations may be true. The conclusion here is we find no validity to any of these potential allegations in the data, that anything is outside of industry norms.

We hired a firm called Opera Solutions. Opera is actually headquartered here in New York. Opera was recently selected by CMS to provide advanced analytical services to their exchanges to actually look for fraud in the exchanges once they are developed. They are very, very reputable firm. We provided Opera our data and said, look at it. We looked at it on a national level, we looked at it on a local level, we looked at it by DRGs and some of the stated peppered approaches. We looked at it even down to the physician level, doing some very advanced analytic techniques.

The conclusion is that our ER rates, and then I walk you through four very brief slides or five slides, that summarize what I am saying. Our ER rates tracked the national ones. If you look at it over the period in question, we did the paired T-squared test, we find no significant difference between the national averages and us.

If you look at our hospitals and you normalize for service lines, different age, different parts of the country, we have an older population in Florida, we find they are is not statistically different than the averages. It is not there. If you look at samples -- statistics from sample hospitals, we find at local level, that we are in line with local averages, local state averages.

John, if John would walk through the slides here, they are hard to read. The first slide is probably the most telling. Our ER admission rate was 13.3% in the start of the period in '08, and we actually, in July, at 11, coincidentally at the exact same. The ups and downs in the chart are winter, flu, it's up in the winter, down in the summer. You guys are the industry experts so this is very familiar. The bottom line, is it has been flat over the period.

If you look at the Medicare rates, the Medicare rates actually decreased if you look at our internal data from 36.4% to 34.4%. Very flat decline. Again, these are in line with the national norms. No statistical significance.

We looked at it sort of by hospital system, and calculated our one-day stay rates. We availed ourselves so the med par data, the HCUP's data, as well as our internal data. Most of the data sources we would have access to. I know many of you have run these analyses yourself. We have seen them in reports. If you look at it by system, it is about -- our one day stay rate is about 10%, and the red bar on the chart up there, it is difficult to read, we are in the middle to the back of the pack. Matter of fact, we have the lowest as of the first couple of months through 2011.

Then we will shift gears for a second here, I will give you a macro level view. Since Carlisle came up in our recent -- a couple days before our last earnings call, there was a report in the Carlisle Sentinel that specifically mentioned Carlisle, and I know one of you, Boyd Witt, mentioned Carlisle this morning in your reports. We mentioned it on our July call as well. I want to give you a little bit of insight into Carlisle for that reason.

If you look at Carlisle's inpatient admission rate by year, it is actually below the national average. We use the other urban averages. There is the urban, other urban and rural. We fall squarely 87% of our hospital, 85% of our hospitals overall are in the other urban category. And all of the hospitals in Pennsylvania are in the other urban category. We are below the national average and we are at or below the Pennsylvania average. There is nothing there.

If you looked at the one-day stay rates in Carlisle, Pennsylvania compared to the national average and the Pennsylvania other urban average as well, we are below those averages. We did not see anything in Carlisle, Pennsylvania, that would indicate anything out of the norm.

With that, we have done exhaustive analysis. We even went to a physician level. I do not have the slide to speak to it, we looked at the number of combinations, emergency room physicians do not admit patients. They must consult with your primary care physician. They must call a specialist, a cardiologist or one of the attendings to admit. They have to partner, as they should, with other folks in the care, making the final admission determination.

We looked at representative hospitals and found 5,000 combinations of the multiple ER docs in the ER with multiple physicians, the primary care docs and others. 5,000 different combinations, so potentially 350,000 just in simple math combinations. It would be very, very difficult. There are a lot of people involved here. We went down to the physician level. I only bring that out to illustrate the level of effort we have gone to, through Opera, to look for anomalies in the data.

With that, I'll turn it back over to John.

John Merriwether - *Health Management Associates Inc - VP of Financial Relations*

Thanks, Eric. I think Alan wanted to add a little something here before we conclude.

Alan Levine - *Health Management Associates Inc - SVP, Florida Group President*

Eric did a great job laying out the slides. I want to add one thing. He mentioned HCUP's, which is the healthcare cost utilization project data. We -- Opera used the HCUP's data in the national emergency data set for looking at our data, primarily because that is the most nationally credible data that is available. It is claims data, it is tens of millions of claims. It is the real data.

There are multiple sources of data you can go to. Most of those other sources are voluntary surveys and other sources of the data. We went to the actual data source that researchers use, that CMS uses, and that the ARC uses. The HCUP's data is ARC data. We went to the government for the government source of the data, which is what is used throughout the industry and by analysts and by experts in analyzing trends in the industry.

That is why we chose that data set. That is why we chose Opera. Opera is a very well regarded nationally. As Eric mentioned, they were selected by CMS to do see CMS's own fraud and abuse detection. We went to the best sources in the industry to do our analysis.

John Merriwether - *Health Management Associates Inc - VP of Financial Relations*

Thanks, Alan. To follow that up, we believe the data are very clear. They provide no basis to support allegations of emergency room admissions. Our confidence that these allegations would not be supported by the data, even before the analysis by the independent third-party, stems in part from our confidence in our very robust and comprehensive compliance program at Health Management.

Every Health Management associate receives compliance training upon being hired and at least annually thereafter. Including the annual review and signing of Health Management's code of business ethics – code of business conduct and ethics. This commitment to our compliance program also extends to our vendors and physicians. We actively encourage our associates to report any questionable activities which might not be in compliance with our code of business conduct and ethics so that we may investigate and resolve the concern. See for yourself, I encourage you to review our code of business conduct and ethics, which can also be found on our website at www.hma.com.

In a moment, we will be happy to take some questions from those here in attendance and answer them as best we can given that we have not seen the story from 60 Minutes. After the story airs, we will discuss whether additional comment or information is necessary. That will conclude our formal remarks. We will take just a couple of seconds here and we will open it up to some questions. Just a few to keep it brief here in the room.

QUESTIONS AND ANSWERS

Unidentified Audience Member - - *Analyst*

Thanks. Can you just talk about whether or not you employed the doc in the ER or -- and especially the ones who are doing (inaudible) or do you outsource the (inaudible) first? And then second, can you discuss sort of who is involved in the decision to admit a patient into (inaudible)?

Alan Levine - *Health Management Associates Inc - SVP, Florida Group President*

Thank you. First, two-part question. The first part is -- are physicians that are in the emergency department employed by us or are they outsourced? The second part of the question is -- what is the process for an admission?

To answer the first question, we do not employ emergency room physicians. They are independent providers, normally under contract. I should also mention, any contract physician is required to comply with our compliance policies as well. But the decision to hire or fire a physician in the emergency room is actually made by the independent group, not by us. We have no direct authority to employ or deal with independent physicians. That is handled through, A, their private group, or B, through the medical staff procedures that are deployed in the hospital through the medical staff processes.

The second part of the question, the decision to admit a patient is a very complex medical decision that is made by, and using the independent medical judgment of a physician. Those are the Medicare guidelines, and we follow those guidelines. It has become more complicated because of the interference in that decision by for-profit, RAC auditors who are paid a contingency fee to come in and substitute their judgment for the judgment of a medical physician who actually examined that patient and made the decision about what was best for that patient. That is the essence of the lawsuit that is going on right now between the AHA and the federal government.

What happens, an ER physician -- an ER patient comes into the hospital. They are evaluated by a triage nurse. The triage nurse takes all their symptoms. Our systems are deployed to do the proper testing, so that when the physician sees the patient, they have all the information they need to do a proper assessment of the patient. Remember, in the ER, timing is everything. If somebody comes in with a chest pain, somebody comes in with a neurological issue, you want to make sure that you diagnose as quickly as possible, so you can get treatment as quickly as possible.

The ER physician, if, in their judgment, they need additional testing, they order additional testing. We encourage the ER physician -- we presume most patients have a physician of their own. Many don't. We encourage the ER physician to contact the patient's private physician because these ER physicians, in most cases, have never seen that patient before. We want them to have as much medical history on that patient as they can.

That private physician consults with the emergency room physician, and the private physician makes the decision whether or not to admit that patient. Sometimes that private physician can be a specialist, for instance, it could be a cardiologist, it could be whatever doctor is on call for that patient's particular type of symptoms. Once the decision is made to admit, then all of those -- by the doctor, then all of the systems are deployed to get the patient as quickly as possible up to a patient room.

Now, here is what also happens. When a patient is admitted to observation status, remember, observation, if you read Medicare's own guidelines, observation is intended to be a 24-hour period or less where the doctor can do additional testing and make their own decision about whether or not to admit the patient. Observation has never been intended to be a substitute for inpatient admission. What you have seen in the Brown University study form 2007 to 2009 is that not only have observations exploded, but the number of observations that have stayed two days or longer has also doubled.

What happens is, you have patients that could be put in observation status; those patients are sent to a floor just like an inpatient is. They are treated the exact same as an inpatient. They get testing, they get the same nursing care, they get the same everything. At the end of the day, the patient often doesn't even know whether they are in observation or in inpatient until they get discharged.

If they are on observation status, they get a bill because it is paid for by Medicare Part B, they have to pay a huge copayment, where they wouldn't have to pay that copayment had they been admitted. And more importantly, clinically, if a patient is put in an observation status that needed to be an inpatient, if that patient needs any post-acute rehab or nursing care, Medicare will not cover it, and the patient will often be asked to pay up to $10,000 or more out of their pocket in order to access those services.

Here is what happens if they can't afford it. The patient ends up coming back to the ER because they could not get the post-acute services they needed. This is the continuum-of-care issue that I raised earlier, and it is the essence of the AHA lawsuit that has been filed. But the process for admitting is a physician in the ER consulting a private physician, and the private physician ultimately making the decision whether to admit that patient or not.

Unidentified Audience Member - - *Analyst*

Thanks. I think earlier you mentioned that there was some adjustment for (inaudible). I'm curious what those adjustments are in the data that you used. Did you just look at the raw data (inaudible) 60 Minutes is not hiring anyone (inaudible). On an unadjusted basis, is there a difference in any of findings (inaudible)?

Alan Levine - *Health Management Associates Inc - SVP, Florida Group President*

I'm going to repeat the question. The question is -- in Eric's remarks earlier related to the differences in each of the markets and how the data may be different in each markets and adjustments. Let me be clear, the only adjustments to the data are actually labeled in the slide, at the bottom of the slide. And what they are adjusted for is we wanted to make sure -- I don't have the slides in front of me, but at the bottom of the slides it references the patients that left without being seen, patients that were transferred to other hospitals, those patients were removed. There was no adjustment made related to different hospitals. The data is absolutely clean.

What Eric was referencing was that each hospital is going to have different admission percentages based on the dynamics in that market. For instance, a rural hospital is going to have a lower admission percentage. We have hospitals that are rural that have a 5% or 6% admissions percentage, whereas a high-volume, high-intensity, sophisticated hospital with all the sub-specialties is probably going to be upwards of -- well, I don't want to guess, but some could be as high as 20% to 30% depending on the type of market. What Eric was referencing is variations by market, and not in terms of adjustments to the data. Any data adjustment is at the bottom of the slide.

Unidentified Audience Member - - *Analyst*

Two questions. Actually one relates to Carlisle specifically. I wonder if you can comment as to whether you made any significant changes in regards to staffing at Carlisle emergency room, and how you think that might have played into this particular story perhaps?

And then, secondly, stepping back and thinking about HMA's data on a consolidated basis, and what you've been reporting, clearly inpatient admissions have been under a significant pressure, and we have seen that trend (inaudible). Your numbers have been, certainly, a little bit worse. And presumably, there is a little bit of relationship to [staff] your rate of growth observation as it relates (inaudible). I would love to get your thoughts on whether you think there's been a specific corporate policy that has had an impact on that trend, whether you think there are more about the internal forces that you mentioned in terms of RACs and that. Would like to get your thoughts on how you think your trends are playing out in relation to the industry (inaudible).

Alan Levine - *Health Management Associates Inc - SVP, Florida Group President*

Yes. Let me repeat. There is two parts to the question. First part was, Carlisle, related to staffing, and have we made changes to staffing at Carlisle. I will come back to that in a minute.

The second part is, and correct me if I misstate your question -- the trends in the industry related to observation and inpatient, and what are we seeing? Is that a correct summary?

Unidentified Audience Member - - *Analyst*

Yes, (inaudible).

Alan Levine - *Health Management Associates Inc - SVP, Florida Group President*

Okay. Let me answer the second one first. In terms of trends in the industry and HMA's metrics -- Health Management's metrics, I can't comment on anything going on currently in the quarter, obviously that will occur through our proper reporting mechanisms.

What I can say is what you have seen is similar to the rest of the industry. In fact, we are seeing, in terms of observations, we are seeing the same trends. We are seeing growth in observations that are over two days. We are seeing -- which is troublesome to us because of the impact on seniors, set aside all of the business metrics here. This is having a disgraceful impact on senior citizens.

When you have a senior citizen with a broken spine that sits in observation for five days and can't get into post-acute rehab, that is a story that ran in an AARP Magazine. It didn't happen in one of our hospitals, but this is what's going on out there, and it is very harmful to seniors. That is really, fundamentally, ethically why we think this needs to be addressed.

But as to the trends, we are seeing the same trends as the rest of the industry. Admissions pressure is the same as what we are seeing in the industry. And Gary Newsome, on one of our previous calls, alluded to one of the challenges you see in our numbers is, truly, if you see the economic variations that are going on with joblessness, in the larger markets where people go for jobs, number one, you see migration towards markets where people go for jobs. And those larger markets are typically not our markets. We are in the secondary and smaller markets primarily. And then those markets are also, typically, the first to come back. And so, we think our metrics will follow; it's what you have been seeing in our quarterly reports.

As to the first question about Carlisle, I'm glad you raised it. I'm going to take a little liberty here; I'm glad Carlisle is coming up. Number one, to be clear, last year, Carlisle was one of the hospitals that was ranked by the joint commission as one of the top-performing hospitals in the United States of America. Based on the process-of-care measures, which are not subjective, they are objective measures. We are very proud of what our staff and our doctors in Carlisle are doing. From 2009 to 2011, Carlisle's staff recruited more than 40 new doctors into that community. They added several new programs there, including a major cancer program. We have seen very good success at Carlisle.

Now, let me tell you what happened to us about one year ago, August a year ago. Because of some of the success we have had with recruitment of physicians and attracting people to that hospital, we saw a sudden growth in our emergency room visits. And our staffing was not prepared for that. That all plays out with the state of Pennsylvania citing us, and all of that. Those issues were addressed. In fact, they were addressed even before the state cited us.

One of the reasons, I should mention, 60 Minutes kept asking me about why we track admission percentages. Any hospital CEO will tell you, one of the biggest challenges you have is staffing. You have to be reactive to your volumes. If you do not have good predictability in your admissions numbers, you are going to have a staffing catastrophe. You are going to either be under-staffed, which is very bad for patients, or you will be over-staffed, which is very bad financially. We track our admission percentages on a daily basis, so that we can project our staffing. That is primarily why we do it. In addition to making sure we're making the right clinical decisions for our patients.

At Carlisle, we got surprised about one year ago with our staffing shortage in the ER. It was addressed. Since then -- in fact, I've got to tell you, today in the newspaper, in one of the two Carlisle newspapers, there is a letter to the editor from a patient who was discharged about a week or so ago and said -- I've been reading all this stuff about Carlisle, I don't know what all you people are talking about, it was the best care I've ever had in a hospital. This was a letter to the editor that was in the paper today. We are pretty darn proud of what's going on at Carlisle, and we're proud of our employees there.

Unidentified Audience Member - - *Analyst*

Thanks, Eric and Alan for all the details. I'm just curious, you've had a bit, or a lot of time to work on this and respond and help us try to understand (inaudible). What level of interaction or engagement have with policy makers or regulators to help inform them of this (inaudible)?

Alan Levine - *Health Management Associates Inc - SVP, Florida Group President*

Great question. The question is -- what interaction have we had with regulators and other policy makers? We have a -- personally, I have spoken with acting Administrator Tavenner to give her a heads-up about the story. We gave her a heads-up about a month or so ago, after I was interviewed. We have met extensively with staff on Capitol Hill to brief them on it.

One of the things that has continued to come up as we've talked to staff on Capitol Hill is, as soon as I talk about this issue, as soon as I mention observation and inpatient, everyone understands the issue. They understand this is a major challenge and it is a subject of major litigation now. We are -- all of our colleagues in the industry, I talk to them all the time, our competitors and other colleagues alike. We are all facing the same challenge. What are we supposed to do?

Here is the bottom line example. If you admit a patient -- if you don't admit a patient, and you place them in observation and they stay in observation for three days, and they receive all these services, and then they get a bill or they can't get post-acute services, we hear about it from the patient, their family, or maybe even their lawyers. We hear from the patient. And we are blamed for it. The hospital is blamed for it. If we admit the patient, or if we advocate for admitting the patient, then we are accused of improperly admitting patients.

Our bottom line is this -- irrespective of all of these other issues that are out there, the guidance that I personally give our doctors and our hospitals is -- do the best for your patients. Do what you think is medically appropriate for your patients. We will deal with all of the other issues later, but do not ever put us in a position of not providing what is best for your patients, strictly for administrative or financial reasons. That is the last thing that you should do.

Unidentified Audience Member - - *Analyst*

Can you remind me when you bought Carlisle?

Alan Levine - *Health Management Associates Inc - SVP, Florida Group President*

That was before I came into the Company.

Eric Waller - *Health Management Associates Inc - SVP and Chief Marketing Officer*

I don't want to guess, but it has been at least 10 years, right?

Unidentified Audience Member - - *Analyst*

If I look at slide 6, the one thing that does provide (inaudible) over the years was below (inaudible). From 2008 to 2010 (inaudible).

Alan Levine - *Health Management Associates Inc - SVP, Florida Group President*

Yes. Thank you for asking. That is exactly a point that I was raising. Let me repeat the question. Looking at the slide from 2007 to 2009 or '10, the overall admission percentage increased. You have to look at this slide side by side with the one-day stays, with the one-day admissions. Let me tell you why.

As I mentioned, in 2008, beginning of 2008, we began doing aggressive physician recruitment into the community, as the community was growing. We recruited more than 40 new doctors into the community from -- it began in 2008, all the way through 2011. We've added several new programs in that hospital, including a cancer program. These are high-acuity programs. Among the doctors recruited were neurosurgeons, general surgeons, oncologists. These are high-acuity doctors. Previously, those patients would be sent somewhere else to be cared for.

Because they can be cared for now at Carlisle, what you will see is your higher-acuity admissions will go up. You have to look at the one-day admissions. The one-day admissions is what CMS looks at. That's where you have potential liability for patients that could have been in observation; those are the ones CMS looks at. The [pepper] data, all that stuff, and they look at your short-stay admissions.

If you look at the one-day admissions, not only are we below the average each of those years, but we were declining in each of those years. If we were doing something inappropriately -- if we were inappropriately admitting low-acuity patients that did not belong in the hospital, you would have seen the one-day admission percentages go up. You would not see them go down. That data is absolutely conclusive.

Unidentified Audience Member - *Analyst*

Great. Thanks. Can you talk about how (inaudible)?

Alan Levine - *Health Management Associates Inc - SVP, Florida Group President*

The question is about ProMED, and how we use it in the ER, and questions about why we stopped using it. First, let me tell you a little bit about what ProMED is. If you Google emergency department IT systems, you'll find probably 10 or 11 different companies that do what ProMED does. A PulseCheck, which incidentally is a system that is used by our competing hospital -- from Carlisle; it is used down the street at one of the other hospitals. PulseCheck does all the same things ProMED does. T-Systems -- there is multiple IT systems that do this.

The American College of Emergency Physicians in 2004 put out a white paper where they talked about the need, effectively, for -- actually, let me back up a minute. There is two big groups that represent ER physicians. The American College of Emergency Physicians, which represents more than 30,000 emergency room physicians throughout the country. And there is the American Academy of Emergency Physicians, which represents I think around 2,000 ER doctors.

The American College of Emergency Physicians is the recognized authority on ER care. We follow their white papers and their guidance very closely. We read what they put out, and we try to follow what they put out. The ACEP recommended, in 2004, a couple of things. Number one, they recommend a triage-based order sets. Basically permitting triage nurses to order tests that are predetermined, based on patient symptoms, so that the test can be done rapidly, so that you can improve throughput through the ER. ProMED does that.

What happens is, a patient comes into the ER and they give us their symptoms. They give the triage nurse their symptoms. You have the triage nurse put the symptoms into the computer, the computer has predetermined test maps, and the process for those test maps to be predetermined is very important. Those test maps are determined by board-certified ER doctors, they are approved by the medical director of the ER in each hospital, and the medical executive committee, the elected medical executive committee of each hospital, which acts independently of the hospital, has to approve all standing orders. These are all covered.

And Joint Commission reviews these as well, as part of the accreditation process. So, all of our hospitals, obviously, are compliant with Joint Commission, and 65% of them are top performers. We follow all of those guidelines to make sure.

The primary issue with ProMED is to, number one, make sure that when a patient comes into the ER, we capture the symptoms appropriately, and we get the proper testing done. Another important feature of ProMED is that the ER doctor can cancel tests that they don't want. And there is what we call true tests and false tests. Meaning, a true test is a much smaller sample of tests where the triage nurse basically hits send and those tests are ordered. There is false tests where the ER doctor has to approve the tests before they are ordered. We believe that ProMED complies with all of the standards in the industry.

When you Google the other systems, the other PulseCheck, T-Systems, and you read the highlights of what those systems do, and you read their case studies, they talk about improving throughput through automated order sets, and evidence-based order sets. That's exactly what ProMED does.

Number two, ProMED also uses what is called -- it uses InterQual criteria, what's called QualCheck. If a patient meets inpatient criteria based on the InterQual criteria, we let the physician -- the system lets the physician know that. The physician then makes the decision whether they want to admit the patient or not. They do not have to admit the patient. They can send the patient home.

Let me tell you what happens. If the patient meets inpatient criteria, we have what is called flash meetings every morning in our ERs. The American College of Emergency Physicians, in one of their white papers, recommended that there be routine communication between administration, nursing, and the ER physicians. We have those meetings every single morning. We talk about patients that left without being seen, patients that were transferred to other hospitals. We talk about patients that met criteria for admission, but weren't admitted. We also talk about patients that were admitted to inpatient that may not have needed to be admitted. We do these realtime audits to make sure that the patient is in the right setting.

The reason we do this is, if a patient meets criteria for admission but is sent home, that patient may be exposed to unnecessary risk. We talk about it to make sure that we have not exposed a patient to risk. Similarly, a doctor might have a patient in the hospital -- they might admit a patient that does not meet InterQual criteria. If that occurs -- and we usually find that out through our audit process. If that occurs, we go to the doctor and we say -- this patient does not meet InterQual criteria, what do you want to do? The doctor has the option of saying -- notwithstanding the fact that it does not meet criteria, I want to keep that patient in the hospital. And we ask the doctor to document the reason for keeping the patient in the hospital. If the patient -- or the doctor can then convert the patient to observation status. That is one of the rubs right now because that patient can be converted to observation and the patient not even know. They think they were admitted, but then they were converted.

The bottom line is that what ProMED does is it basically, if you have read the Checklist Manifesto that Atul Gawande wrote, ProMED and all of these IT systems are nothing more than a checklist for doctors, so that they make sure that they do not miss anything, so that they do not expose a patient to unnecessary risk. No matter what we do in the ER, no matter what happens after the ER, there are multiple audit systems in place, either through our own Company or through the RAC audit process. It is really important for us to get it right. That's why we use these metrics.

Eric Waller - *Health Management Associates Inc - SVP and Chief Marketing Officer*

The only thing I'll add on the lingering ProMED question, because it tends to come up, and we made available on our website the ProMED timeline. I know the issues with Tenet and the ProMED -- the CHS, excuse me, and the ProMED. We make available a timeline when we made the decision to go from ProMED to MEDHOST. There are links to internal documents where we set up a committee to look at the software. These pre-date any sort of public problem or issue with ProMED.

To sort of give you the business outline, I think we've got three or four different internal memos and a timeline, ultimately, we'd like to sort of put the decision to switch from ProMED to MEDHOST to rest. It was purely a business decision. It had nothing to do with any problems with ProMED, and that is available on the website as well.

Unidentified Audience Member - - *Analyst*

Thanks. Maybe just a few follow ups and clarifications. First, it seems like it's all Carlisle is the focus [to your extent]. To be clear, was there any other hospitals or any other companies or anything that we should be thinking about that could be part of the story as far as your sense?

Alan Levine - *Health Management Associates Inc - SVP, Florida Group President*

The question is whether there is any other hospitals other than Carlisle. At this point, we do not know.

Unidentified Audience Member - - *Analyst*

And then (inaudible), the data that you showed today, did you give that to CBS? Are they aware of that data or --

---

Alan Levine - *Health Management Associates Inc - SVP, Florida Group President*

The question is whether we gave this data to 60 Minutes, and the answer is yes.

Unidentified Audience Member - - *Analyst*

You mentioned also, just to be clear, were patients that were in these settings, was the analysis that you had done, we didn't see any of that data. Just wanted to make sure you had the chance to follow up and describe your findings on that note.

Alan Levine - *Health Management Associates Inc - SVP, Florida Group President*

The question is tests per patient in the ER. I will tell you, we are very comfortable, based on the data that we have seen, that our test per patient has not changed. Pre ProMED -- excuse me, in the last -- what was the date that we looked at --?

Eric Waller - *Health Management Associates Inc - SVP and Chief Marketing Officer*

Same sort of time period, we look at the average test by Medicare patient and average test ordered by all patients, and we found no changes.

Unidentified Audience Member - - *Analyst*

Great.

Alan Levine - *Health Management Associates Inc - SVP, Florida Group President*

One more?

Unidentified Audience Member - - *Analyst*

I just want to follow up on -- you talked about the ability of physicians to override the ProMED system to their discretion (inaudible). Given these stats, do you know what percentages of docs actually go against what ProMED says? Is it a high percentage, a low percentage?

Alan Levine - *Health Management Associates Inc - SVP, Florida Group President*

The question is what percentage of the docs override ProMED -- we don't really know that. I should also add, each hospital's test maps can be different based on the local medical staff's preferences. We wouldn't have any way of centrally measuring that. But what we would expect is that if an ER doctor was routinely overriding or saying -- I don't want a certain test, we would presume that the ER doctor would talk to the ER medical director, and they would eventually change that order set to better reflect what the local physician wants. At the end of the day, the physician is ultimately the one that has to do the orders.

John Merriwether - *Health Management Associates Inc - VP of Financial Relations*

Great. Thanks, everybody. That's going to wrap up the call. We appreciate your attention. Have a great day.

Alan Levine - *Health Management Associates Inc - SVP, Florida Group President*

Thank you.

Operator

Ladies and gentlemen, this concludes today's conference call. You may now disconnect.

December 03, 2012 01:45 AM Eastern Time

Health Management Issues Statement in Response to Inaccurate "60 Minutes" Report

NAPLES, Fla.--(BUSINESS WIRE)--**Health Management Associates, Inc. (NYSE: HMA)** today commented on a report regarding the company on the television program *60 Minutes*.

According to their report, *60 Minutes* conducted more than a year of research and found no issues with the quality of care at Health Management hospitals, stating on the broadcast that "hardly anyone we talked to complained about the quality of care at HMA hospitals."

"hardly anyone we talked to complained about the quality of care at HMA hospitals."

It was also notable that *60 Minutes* failed to identify a single patient who had been inappropriately admitted from any of the company's emergency rooms, including by the physicians interviewed.

Neither *60 Minutes* nor the physicians interviewed identified any admission decision in which a physician's medical judgment was overridden by an HMA executive, much less to defraud Medicare.

60 Minutes did not in any way dispute the admissions data it was provided by Health Management over the last several months. That data demonstrated that admissions rates from the company's emergency rooms were in-line with national norms and consistent over a several year period.

Instead, *60 Minutes* relied entirely on disgruntled former employees of the company and former contracted physicians, several of whom are seeking financial gain through active litigation with Health Management.

On November 30, 2012, just after being notified that *60 Minutes* was moving forward with its broadcast, Health Management held a conference call in which it provided key data about admissions from its emergency rooms. The information presented on the call, and additional information added since the program's airing, are instructive about the *60 Minutes* segment and available for viewing on the Investor Relations section of HMA.com.

Health Management enables America's best local health care by providing the people, processes, capital and expertise necessary for its hospital and physician partners to fulfill their local missions of delivering superior health care services. Health Management, through its subsidiaries, operates 70 hospitals with approximately 10,500 licensed beds in non-urban communities located throughout the United States.

All references to "Health Management," "HMA" or the "Company" used in this release refer to Health Management Associates, Inc. and its affiliates.

Forward-Looking Statements

This press release contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended, and Section 21E of the Securities Exchange Act of 1934, as amended. Forward-looking statements are subject to risks, uncertainties and assumptions and are identified by words such as "expects," "estimates," "projects," "anticipates," "believes," "intends," "plans," "may," "continues," "should," "could" and other similar words. All statements addressing operating performance, events or developments that Health Management Associates, Inc. expects or anticipates will occur in the future, including but not limited to incurrence of indebtedness, projections of revenue, income or loss, capital expenditures, earnings per share, debt structure, the provision for doubtful accounts, capital structure, repayment of indebtedness, the amount and timing of funds under the meaningful use measurement standard of various HCIT incentive programs, other financial items and operating statistics, statements regarding the plans and objectives of management for future operations, innovations, or market service development, statements regarding acquisitions, joint ventures, divestitures and other proposed or contemplated transactions (including but not limited to statements regarding the potential for future acquisitions and perceived benefits of acquisitions), statements of future economic performance, statements regarding legal proceedings and other loss contingencies, statements regarding market risk exposures, statements regarding the effects and/or interpretations of recently enacted or future health care laws and regulations, statements of the assumptions underlying or relating to any of the foregoing statements, and other statements which are other than statements of historical fact, are considered to be "forward-looking statements."

Because they are forward-looking, such statements should be evaluated in light of important risk factors and uncertainties. These risk factors and uncertainties are more fully described in Health Management Associates, Inc.'s most recent Annual Report on Form 10-K, and Quarterly Report on Form 10-Q for the quarterly period ended June 30, 2012, including under the heading entitled "Risk Factors." Should one or more of these risks or uncertainties materialize, or should any of Health Management Associates, Inc.'s underlying assumptions prove incorrect, actual results could vary materially from those currently anticipated. In addition, undue reliance should not be placed on Health Management Associates, Inc.'s forward-looking statements. Except as required by law, Health Management Associates, Inc. disclaims any obligation to update its risk factors or to publicly announce updates to the forward-looking statements contained in this press release to reflect new information, future events or other developments.

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Vice President of Financial Relations

OPPENHEIMER

EQUITY RESEARCH

COMPANY UPDATE

December 3, 2012

HEALTHCARE/HEALTHCARE SERVICES

Health Management Associates

Negatively Biased "60 Minutes" Segment Aired

Stock Rating:

OUTPERFORM

12-18 mo. Price Target	$11.00
HMA - NYSE	$7.95
3-5 Yr. EPS Gr. Rate	10%
52-Wk Range	$8.69-$4.81
Shares Outstanding	256.4M
Float	245.3M
Market Capitalization	$2,038.1M
Avg. Daily Trading Volume	3,840,514
Dividend/Div Yield	NM/NM
Book Value	$3.66
Fiscal Year Ends	Dec
2012E ROE	21.7 %
LT Debt	$3,476.4M
Preferred	$204.3M
Common Equity	$955M
Convertible Available	Yes

EPS Diluted	Q1	Q2	Q3	Q4	Year	Mult.
2011A	0.22	0.20	0.17	0.26	0.84	9.5x
2012E	0.24A	0.21A	0.18A	0.20	0.83	9.6x
2013E	0.24	0.22	0.21	0.23	0.90	8.8x

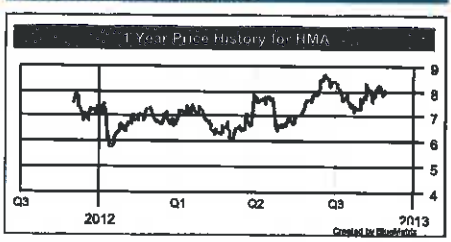
SUMMARY

As foreshadowed by HMA late last week, the show "60 Minutes" produced a segment, attempting to show that HMA pressured doctors to unnecessarily admit patients in order to boost profits. HMA responded, noting among other things how the show did not identify a single admission decision in which a physician's medical judgment was overridden by an HMA executive, much less to defraud Medicare. The company also noted that the show did not dispute the hard company-wide data, suggesting stable and in-line ER metrics. What we were left with, in our opinion, was a fluffy report based solely on the opinion of disgruntled employees. While to us the show's negative bias was very clear, there really was no specific evidence of any wrongdoing.

KEY POINTS

- HMA responded to the story, saying 1) quality of care was not questioned by the show, 2) the show did not identify a single example where a patient was inappropriately admitted or where the company's executives overrode a physician's judgment, and 3) the show did not dispute data provided by HMA over the last several months.
- On last Friday's call, HMA presented some of that data. The data showed how its 5-year ER admission rates have remained stable in the 13% area (below the 20% goals mentioned on the show), while one-day stays are near the low-end of industry averages.
- Furthermore, we note that the ER doctors are not even employed by HMA directly (the company outsources its ER operations). Last week, the company said that "the decision to hire or fire a physician in the ER is...made by the independent group..."
- Clearly, profits are important to for-profit healthcare providers. Also, this is not the first time, nor the last, that the gray areas in our country's healthcare system will be exposed. However, there is a large gap between what was shown on that segment and proving healthcare fraud.
- Overall, we believe the show's negative bias, fluffy evidence and reliance on disgruntled employees did not convince us of any wrongdoing at the company. We are glad this long-lasting overhang is now in the past and reiterate our Outperform rating.

Stock Price Performance



Company Description

Health Management Associates, Inc. is a hospital management company based in Naples, FL. The company focuses on non-urban markets in the Southeast/ West regions of the US.

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UBS

UBS Investment Research

Health Management Associates

Long-Awaited "60 Minutes" Piece Airs

■ As Expected, Some Harsh Allegations

The TV show "60 Minutes" aired its long-anticipated story on HMA admissions practices on Dec 2. The 15 minute segment closely followed the themes that HMA management had suggested it would when they previewed the piece on Nov 30.

■ Real Evidence of a Systemic Problem Are, However, Still Lacking

What has been lacking all along in the press reporting about HMA, and what was not provided last night, is an objective analysis or data that indicates the company was successful in systemically admitting a higher percent of its ER patients than is the industry norm. For its part, HMA offers independent analysis by a well-regarded third party reviewing organization that says the company's percent of ER admits are at or below industry norms and are well below the "targets' that "60 Minutes" says were being used.

■ Media Scrutiny Has Likely Contributed to Recent Soft Admits

The pending release of the "60 Minutes" story has been an overhang for HMA. Given the widespread press reporting over the last six months, we now believe buzz that admission criteria were under scrutiny in the media (and already by the government) likely account for the incremental weakness observed in HMA volumes this year.

■ Valuation; We Think Shares Are Already Discounting Media/Govt Noise

HMA shares trade at 8.8x 2013E EPS and 5.8x 2013E EBITDA ests (Ex-HITECH). Our PT of $11 is based on 6.5x our 2013 EBITDA estimate (ex-HITECH).

Highlights (US$m)	12/10	12/11	12/12E	12/13E	12/14E
Revenues	5,156	5,806	6,716	7,012	7,381
EBIT (UBS)	489	542	552	606	664
Net Income (UBS)	163	197	203	232	269
EPS (UBS, US$)	0.65	0.77	0.79	0.90	1.02
Net DPS (UBS, US$)	0.00	0.00	0.00	0.00	0.00
Profitability & Valuation	**5-yr hist av.**	**12/11**	**12/12E**	**12/13E**	**12/14E**
EBIT margin %	9.5	9.3	8.2	8.6	9.0
ROIC (EBIT) %	12.2	13.0	12.0	12.7	13.3
EV/EBITDA (core) x	7.0	6.6	5.8	5.1	4.6
PE (UBS) x	13.1	11.9	10.1	8.9	7.8
Net dividend yield %	18.8	0.0	0.0	0.0	0.0

Source: Company accounts, Thomson Reuters, UBS estimates. (UBS) valuations are stated before goodwill-related charges and other adjustments for abnormal and economic items at the analysts' judgement.
Valuations: based on an average share price that year, (E): based on a share price of US$7.95 on 30 Nov 2012 19:37 EST

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Global Equity Research

Americas

Healthcare Providers

12-month rating	**Buy** *Unchanged*
12m price target	US$11.00 *Unchanged*
Price	US$7.95

RIC: HMA.N BBG: HMA US

3 December 2012

Trading data	
52-wk range	US$8.66-5.78
Market cap.	US$2.04bn
Shares o/s	256m (COM)
Free float	95%
Avg. daily volume ('000)	635
Avg. daily value (m)	US$5.0

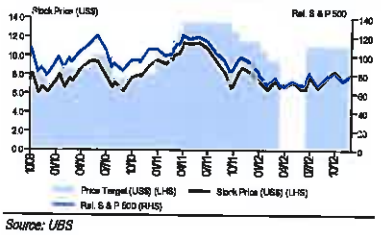
Balance sheet data 12/12E	
Shareholders' equity	US$0.95bn
P/BV (UBS)	2.1x
Net Cash (debt)	(US$3.49bn)

Forecast returns	
Forecast price appreciation	+38.4%
Forecast dividend yield	0.0%
Forecast stock return	+38.4%
Market return assumption	5.3%
Forecast excess return	+33.1%

EPS (UBS, US$)

	12/12E		12/11
	UBS	Cons.	Actual
Q1	0.23	0.24	0.22
Q2	0.21	0.21	0.20
Q3	0.17	0.18	0.20
Q4E	0.18	0.19	0.17
12/12E	0.79	*0.82*	
12/13E	0.90	*0.90*	

Performance (US$)



Source: UBS

www.ubs.com/investmentresearch

Health Management Associates Inc.

60 Minute Segment a Rehash of Old News

Summary

We would be buyers of HMA on any weakness related to last night's 60 Minute segment. We learned nothing new from the segment and, more importantly, we do not believe there was anything in the segment that would widen the government's already 17-month investigation into HMA's emergency room practices. More importantly, we think at 5.2x our 2013 EV/EBITDA vs. the group average of 6.0x, the stock already reflects the investigation risk.

Key Points

- **We learned nothing new from the 60 Minute segment and the government likely did not either.** HMA received a subpoena from the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) on July 21, 2011 requesting documents on ER management including use of Pro-Med software. The investigation was likely prompted from qui tam lawsuits (typically filed by ex employees). After 17-months of investigation, we would be surprised if the government learned anything new and, as a result, we think it is unlikely the government will widen its investigation based on last night's 60-minute segment.

- **Impact to operations.** Given the length of time the subpoena has been outstanding and previous news coverage surrounding this issue, we think the 60-minute segment will have little impact on physician referrals, recruiting or acquisitions for HMA.

- **What the segment did not disclose.** We would be more concerned if the segment cited specific patients who believed to be wrongfully admitted, specific proof that ER doctors were forced to admit patients regardless of medical necessity or if the segment disclosed other new information not already in the public arena. None of this happened.

- **Too early for financial impact.** It is unclear at this time how serious, if at all, this could be for HMA, but we suspect any financial impact from these investigations should be minimal. Further, the data HMA presented on Friday (conducted by an independent organization) which illustrates HMA's admission trends are in-line with the industry average, is more telling to us than a television segment interviewing ex employees.

- **Risk reward attractive at current levels.** HMA currently trades at 5.2x our 2013E EV/EBITDA, versus its two and five year forward historical EV/EBITDA averages of 6.5x and 6.7x respectively. Our price target of $11 is based on 6.0x our 2013E EV/EBITDA. We think the risk reward is attractive at current levels and the investigation is reflected in current valuation. We would be buyers of HMA on any weakness.

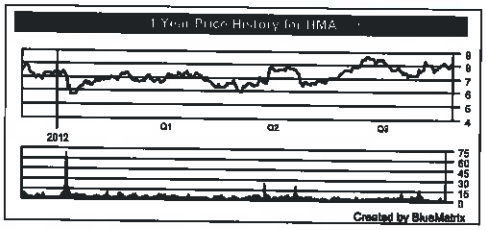
Rating	**Buy**
Previous Rating	–
Price (11/30)	**$7.95**
Price Target	**$11.00**
Previous Price Target	–

Key Data

Symbol	HMA (NYSE)
52-Week Range	8.69 - 4.81
Market Cap ($M)	$2,038
Shares Outstanding (M)	256.4
Float	246.6
Average Daily Volume	3,840,514
Dividend per Share ($)	0.00

Fiscal Year-End: Dec 31

	2012E	2013E Prior	2013E Curr	2014E Prior	2014E Curr
Revenue ($M)					
Q1	1,485.3A	–	1,571.4E	–	1,645.3E
Q2	1,472.0A	–	1,533.9E	–	1,606.6E
Q3	1,440.1A	–	1,501.1E	–	1,571.5E
Q4	1,485.6E	–	1,552.3E	–	1,625.8E
Yr	**5,882.9E**	–	**6,168.7E**	–	**6,449.2E**
P/ Revenue	0.3x	–	0.3x	–	0.3x
Earnings per Share ($) Non-GAAP					
Q1	0.19A	–	0.21E	–	0.23E
Q2	0.17A	–	0.19E	–	0.26E
Q3	0.18A	–	0.20E	–	0.24E
Q4	0.29E	–	0.30E	–	0.30E
Yr	**0.83E**	–	**0.90E**	–	**1.03E**
P/E	9.6x	–	8.8x	–	7.7x



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HEALTH MANAGEMENT ASSOCIATES (NYSE: HMA, OUTPERFORM)

Show May Pressure DOJ Action on Long-Standing Subpoenas; Risk Appears Modest

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HEALTHCARE EQUITY RESEAR

Public link to the document : View Document

Bottom Line. Last night's long awaited CBS 60 Minutes episode focused on allegations that HMA is pressuring its physicians to admit emergency room (ER) patients regardless of medical need. The show primarily relied upon interviews with previously contracted physicians and several former employees and did not offer any statistical evidence to back up its claims. While we believe the show may pressure the DOJ to move forward on several long-standing subpoenas relating to HMA's ER management and use of Pro-Med software, we believe that HMA's practices are in line with industry standards and that the overall financial and operating risk from the investigation is modest.

• **Limited Impact on Acquisition Pipeline Expected.** As THC's (MP) allegations and the government investigation on CYH's (MP) admission policies did not stop that company from finding willing acquisition candidates, we do not believe HMA is likely to have a problem either.

• **Specific Allegations Not Supported by Admissions Data.** The primary accusation raised in the 60 Minutes episode was that HMA pressured its physicians to reach certain admission rates in its ERs. Interviewed physicians said they felt pressure to admit at least 15-20% of ER patients and 50% of Medicare ER patients, which contrasts with HMA's self-reported multi-year national level ER admission statistics in the low teen (~13%) range and for Medicare in the mid-30% range, as presented on Friday (11/30) by management.

• **Show Also Highlighted Previously Discussed Issues.** The 60 Minutes episode also included an interview with former auditor Paul Meyer, who has filed a whistle-blower lawsuit against the company over a year ago. Interestingly, Meyer's suit appears to be focused on the industry's well known short-stay admission/observations status classification controversy, but that wasn't mentioned on the show. In addition, the show discussed the company's use of ProMed software, on which HMA was subpoenaed about 18 months ago and has since discontinued using.

• **Generating Revenue is an Industry Issue.** Similar to the investigation of unnecessarily cardiac procedures at several HCA (OP) hospitals, we believe the pressure on HMA's hospitals to generate revenue, as highlighted on the 60 Minutes episode, could be applied to most hospitals in the country that have a budget to meet and salary and capital expenses to cover. In addition, the current transition from a healthcare system that relies solely on physician opinion to a more standardized, evidence-based system creates significant opportunities to second-guess historical practices, but that doesn't imply intentional fraud.

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2 December 2012 | 7 pages

Health Care Facilities (GICS) | Health Care Facilities (Citi)
North America | United States

Health Management Associates (HMA)

■ Company Update

Alert: Summarizing "60 Minutes" Allegations

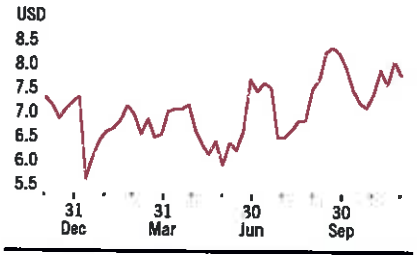
Conclusion – Sunday evening the "60 Minutes" news program aired a story accusing HMA of improperly pressuring its emergency room physicians to admit patients for inpatient status. HMA had previewed the possibility of this story a few months ago and again on Friday with an investor call. The story did not change our opinion on this matter. While some similarities exist to the allegations made last year against CYH, we believe HMA's aggregate ER conversion rates and 1DS data do not support a theory of material Medicare liability for the company.

"60 Minutes" – Claims to have talked to 100 employees and physicians, and 6 appeared on camera. Jon Volmer was a divisional executive (no longer with the company) who was well-known by Wall Street. Paul Meyer was the ex-compliance executive who filed a wrongful termination suit (in which he alleged MDCR fraud for medically unnecessary admissions at Florida hospitals) in January 2012. The story included a couple of emails allegedly illustrating HMA hospital executives pressuring certain ER staff to increase their admission rates. "60 Minutes" claims to have asked HMA CEO Gary Newsome to appear on camera, but he declined.

Some Similarities to CYH – CYH is currently the subject of a national OIG investigation into its emergency room admission practices. There are some similarities: HMA's CEO Gary Newsome joined HMA in late 2008 after spending 10 years working as a Group VP and a Division President for CYH. Both CYH and HMA were the only publicly-traded hospital companies to use the ProMed ER software. Finally, CYH and HMA experienced the sharpest declines in SS inpatient admissions during 2011 once the CYH allegations were made.

Buy/High Risk	1H
Price (30 Nov 12)	US$7.95
Target price	US$9.00
Expected share price return	13.2%
Expected dividend yield	0.0%
Expected total return	**13.2%**
Market Cap	US$2,038M

Price Performance
(RIC: HMA.N, BB: HMA US)



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